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June 29, 1984

SAN FRANCISCO  
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Homeless Program...  
Proposal*

Philip S. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital & Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Dr. Brickner:

Attached are twenty copies of the San Francisco Department of Public Health's proposal to the Health Care for the Homeless Program.

This proposal is the result of a cooperative planning effort between the Department and the major public and providers of services for the homeless in San Francisco. When the planning effort began over six months ago, it was apparent that there were few data available regarding

- o the medical problems of the homeless in San Francisco
- o the ways in which the homeless currently receive health care
- o the best ways to deliver health services to the homeless.

Consequently, the Department embarked on an intensive effort to collect data on the homeless (Appendix 1 and 2).

The recently acquired data indicate that the Department, which has an extensive network of outpatient and inpatient services for the indigent, is currently providing enormous resources annually for the homeless. Nevertheless, none of the Department's services are specifically oriented to meeting the special needs of the homeless. In fact, there are major barriers for the homeless to receive health care. These barriers are partially responsible for the common failure of the homeless to receive appropriate timely interventions.

The planning efforts and recent research have greatly increased the awareness of the Department of the seriousness of the health problems of the homeless and have provided the foundation for intensified planning efforts. Yet, much remains to be accomplished. More information must be acquired regarding the health problems of the homeless and ways to improve health care for this population. In the meantime, the homeless continue to require health services to meet their specific needs.

D REF 362.1042 Sa52h

San Francisco (Calif.).  
Dept. of Public Health.  
[Health care for the  
homeless program] /  
1984.

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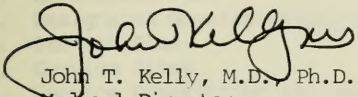
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The Department is committed to ongoing planning and services for the homeless. However, at this time, the Department does not have the resources to establish health services specifically designed for the homeless. The Department is pleased to submit this application, because it is expected that the activities funded through this program will provide essential information for long-range planning and will provide important health services for the homeless.

Although the Department has made great strides during the last six months in designing services for the homeless, much planning remains to be done. As a result, the Department reserves the right to make minor amendments to our plans prior to the site visit.

I would like to thank you for considering the Department's application and I would like to commend you and your staff for your roles in facilitating the development of the Health Care for the Homeless Program.

Sincerely,



John T. Kelly, M.D., Ph.D.  
Medical Director  
Medically Indigent Adult Program

JTK/ac

Attachments





## HEALTH CARE FOR THE HOMELESS

Application

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APPENDICES

1. Demographic studies of the homeless population
2. Health problem studies of the homeless population
3. Directory of services to the homeless (if available)
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6. Organizational chart
7. Training Program for Shelter Providers
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9. Request for Project Support
10. Publications



## HEALTH CARE FOR THE HOMELESS

## I. Application Face Sheet\*

Name of City San FranciscoName of Coalition San Francisco Department of Public HealthDesignated Grantee Organization San Francisco Department of Public HealthAddress 101 Grove StreetCity San Francisco State CaliforniaZip Code 94102 Phone ( 415 ) 558-2386Name of Contact Person John T. Kelly, M.D., Ph.D.Title of Contact Person Medical Director, Medically Indigent Adult ProgramAddress 101 Grove StreetCity San Francisco State CaliforniaZip Code 94102 Phone ( 415 ) 558-2386

\* Information provided by Program applicants may be used by the United States Conference of Mayors for purposes of analysis and possible publication. Please check the box below if you wish to have the contents of this application held confidential. ☐





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**II. Coalition Organization**

List all coalition organizations according to this format:

Organization San Francisco Department of Public Health

Contact Person John T. Kelly, M.D., Ph.D.

Address 101 Grove Street, Room 323

City San Francisco

State California

Zip Code 94102

Phone (415 ) 558-2386





III. Mayoral Endorsement

Insert here a letter from the mayor of your city endorsing this application.

See pages 4-5





June 28, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital & Medical Center  
153 West 11th Street  
New York, New York 10011

Dear Dr. Brickner:

I am writing to express my strong support of the \$1.4 million grant application being made by the San Francisco Department of Public Health. These monies are available from the "Health Care for the Homeless Program," established by The Robert Wood Johnson Foundation and The Pew Memorial Trust.

According to information provided me by the Department of Public Health, a large number of the persons admitted to San Francisco General Hospital are homeless. They require a wide variety of medical services for illnesses and conditions directly related to their homeless status. Many of these costly admissions would not have been necessary if there had been a more timely intervention and identification of these patients' needs.

The attached application proposes the expansion of the capability to provide early medical triage and intervention. By locating satellite clinics in the shelters and expanding the hours of existing satellite services, the timely identification of appropriate medical treatment will be possible. This is not only the most humane manner of dealing with these persons' medical problems, but it will be cost effective in reducing the number of homeless persons admitted to the hospital.

Since December 1, 1982, San Francisco has maintained a shelter and feeding program for the City's less fortunate. I am proud that for more than 310,000 times this City has provided beds and meals for those unable to care for themselves. And, we are committed to continue this much needed effort. I envision the provision of medical services as described in this application as a key ingredient to the comprehensive approach we have undertaken to address the problems of our homeless population. We will continue to do all we can to assist these persons to once again become self sufficient.



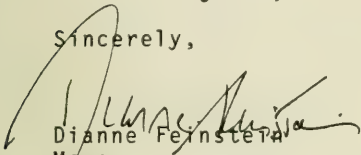


Dr. Philip W. Brickner  
Letter/June 28, 1984  
Page Two

I strongly request the enclosed proposal receives the level of funding applied for to enable us to more completely address the complex needs of our City's less fortunate people.

Warmest regards,

Sincerely,



Dianne Feinstein  
Mayor

DF/dl:mc

Attachment

2359U



## IV. Project Summary

Write here a one- to two-page abstract summarizing the objectives of your proposal, the plan for achieving the objectives, and the specific activities to be supported by the Foundations' funds. [20 extra copies of this abstract will need to be printed and forwarded, in addition to 20 complete copies of the entire grant application.]

See pages 7-8





#### IV. Project Summary

The San Francisco Department of Public Health proposes to establish a program of medical and psychiatric services for homeless adults and youth. This program, entitled "Sheltercare", is designed to provide health services in conjunction with a variety of service programs for the homeless that are already in existence, including the four major emergency shelters, a multiservice center for homeless youth, and a model free medical clinic for indigent patients.

The goal of "Sheltercare" is to increase the accessibility, the continuity, and the coordination of health services for the homeless. Medical and mental health services will be provided in a cost-effective manner that relies heavily on non-physician providers, such as nurse practitioners, and on volunteers. The program will employ a case-management approach, with aggressive efforts to "track" patients, to provide prevention, early intervention, and appropriate triage. Health services will be coordinated with social services to improve access to existing benefit programs. Essentially all of the funds provided by the grant will be used for direct patient services, as the Department will provide the necessary resources for administration and planning.

Clinics, located in emergency shelters and other facilities used by the homeless, will identify the disabled, develop and initiate treatment plans, provide ongoing treatment and case management, and facilitate referrals to the broad range of inpatient and outpatient facilities



operated by the Department of Public Health.

Another important component of the Program is a long-range planning effort to identify the needs of the homeless, determine the most promising methods to improve health care for this population, and to obtain additional resources to provide for the homeless.

The program will be conducted with the extensive resources of the Department of Public Health. Assistance will be provided by two advisory bodies already in existence: a Medical Advisory Committee, consisting of the Medical Directors of San Francisco General Hospital (Emergency, Outpatient, Inpatient, and Adolescent), Community Mental Health Services, and a number of other community clinics; and a Community Advisory Committee, consisting of representatives of the Mayor and the Director of the Department of Social Services, as well as the Directors of the Salvation Army, Saint Vincent de Paul Society, and other charitable organizations that provide services to the homeless.

"Sheltercare" is designed to establish a coordinated approach to medical care for the homeless and to provide the foundation for subsequent efforts of the San Francisco Department of Public Health to improve health services to this population.



**V. Project Service Area**

Give the boundaries of the service area of the project and describe any specific characteristics of the area (e.g. economic, geographic) that may influence homeless people and homeless issues. State briefly the reasons for homelessness in your city.

See pages 10-12

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**VI. Homeless Demographics**

Describe the homeless population in your city and estimate their total number. List the subgroups used to identify this population, describe their characteristics, and estimate the percent of the total for each. Attach any supporting documentation to the application as Appendix 1.

See pages 13-16





## V. Project Service Area

### Reasons for Homelessness

Homelessness has been a chronic problem in San Francisco since its founding in the middle of the Nineteenth Century. In the 1890's, for example, hundreds of vagrants camped in the City (Tenderloin Ethnographic Research Project, 1978). For decades, the typical homeless person has been the chronic alcoholic, who is characteristically single, unemployed, and male. Up to 200 homeless men were housed and fed daily by the Saint Vincent de Paul Society from 1928 to the 1950's at St. Patrick's Shelter.

During recent years, the problem of homelessness in San Francisco has increased dramatically (Appendix 3.1). Many contributing factors have been identified, including:

- deinstitutionalization: the number of state psychiatric hospital beds for the severely mentally disturbed in California has declined precipitously, from 1 bed for each 430 state residents in 1960 to 1 bed for each 4800 state residents in 1983; because of fiscal constraints, residential treatment programs have been unable to provide for many of those who previously would have been in state hospitals; consequently, many mentally ill persons are undertreated, untreated, and homeless
- insufficient housing for low income people: as a result of "urban renewal", much of the housing previously available to



the economically disadvantaged has been razed or converted to other uses; during the last eight years alone, the number of residential hotel rooms in San Francisco has declined by over 35%

- unemployment: episodic increases in the local unemployment rate have forced many into temporary or permanent poverty; similar episodic increases in unemployment elsewhere in the nation have led many to come to San Francisco, where they are often unable to find employment.

### Project Service Area

Although homeless people live throughout San Francisco, in emergency shelters, abandoned buildings, and parks, the area of the City which has been most severely impacted by homeless people is the Tenderloin/South of Market Area, a 100 block section in the center of the City characterized by a high proportion of old buildings, many with single room apartments, a high crime rate, and a high incidence of poverty. Over one-third of the General Assistance ("Welfare") recipients live in this area, which has less than 10% of the City's population.

The Tenderloin/South of Market Area is the area in which most of the homeless live and where most of the service programs for the homeless are located. Among the service programs in this area are:

- shelter: emergency shelters, supported by public and private funds, which shelter approximately 400 homeless persons each night; emergency hotel shelters, supported by public funds,





which shelter approximately 800 homeless persons each night

- food: St. Anthony's Dining Room, which provides free meals to 2000 to 2500 indigent persons daily; Glide Church, which provides free meals to 2200 indigent persons daily
- social services: the San Francisco Department of Social Services, which provides financial support and a broad range of other social services; the Social Security Administration; a broad range of private social services agencies, including the Salvation Army, Saint Vincent de Paul Society, St. Anthony's Foundation, and Larkin Street Youth Center.

Because of the large concentration of homeless persons and programs for the homeless in the Tenderloin/South of Market area, this section of the City has been selected as the service area of the project.

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## VI. Homeless Demographics

Despite repeated efforts to estimate the numbers of homeless persons in San Francisco, it is not known how many people are actually homeless in San Francisco. Nevertheless, it is evident that the numbers of homeless persons have increased dramatically in recent years. Since December of 1982, when the City's Shelter for the Homeless Program was founded, an average of almost 1200 persons have been sheltered nightly. Official City policy is to provide shelter to everyone who requests such. However, there are many more homeless than the 1200 people in the shelters each night.

Estimates of the numbers of homeless in San Francisco have varied from a low of 3000 to a high of 15,000. The United States Department of Housing and Urban Development estimated in the Spring of 1984 that there were between 7,700 to 8,800 homeless persons in San Francisco. Despite the elusiveness of the numbers, it is evident that the homeless present a major problem for the City.

Defining the characteristics of the homeless is as difficult as defining their numbers. Monthly surveys of persons using the emergency shelters (Appendix 1.1), compiled from questionnaires completed by the shelter residents, revealed the following composite characteristics of this population:



Sex

Male 78%  
 Female 22%

Age

Range: 18-80  
 Median: 31.4 years

Length of Time in City

0 - 3 months 33%  
 4 - 6 months 11%  
 7 - 11 months 6%  
 1 - 2 years 10%  
 2 or more years 38%  
 Unknown 1%

Employment History

None 7%  
 Part Time 10%  
 Short Term 9%  
 1 year or more 71%  
 Unknown 3%

Marketable Skills

Yes 68%  
 No 28%  
 Unknown 4%

Ethnicity

White 52%  
 Black 28%  
 Hispanic 11%  
 Asian 2%  
 American Indian 3%  
 Other 3%  
 Unknown 2%

Marital Status

Single 69%  
 Married 7%  
 Widowed 4%  
 Divorced/Separated 18%  
 Unknown 2%

Education

None 2%  
 Elementary School 18%  
 High School 56%  
 Current College 1%  
 College Degree 17%  
 Trade/Business 5%  
 Unknown 2%

Physical Disability

None 68%  
 Temporary 12%  
 Permanent 17%  
 Unknown 3%

Mental Disability

Yes 12%  
 No 77%  
 Unknown 11%

Drug Abuse

None 79%  
 Some Level 18%  
 Unknown 4%

Alcohol Abuse

None 60%  
 Some Level 37%  
 Unknown 3%

Veteran Status

Yes 32%  
 No 65%  
 Unknown 3%



The incidence of serious mental disability is likely considerably greater than 12%, and may exceed 40%, as 34.7% of a sample of 170 homeless persons interviewed in March, 1984 admitted to a history of psychiatric hospitalization (Appendix 2.2). The incidence of substance abuse is likely greater than 37%, and may exceed 60%, as 57.6% of those interviewed admitted to a history of substance abuse.

Another major group of homeless persons are homeless youth. A comprehensive report on the problem, prepared in March, 1984 by the Mayor's Criminal Justice Council, estimated that there are approximately 1000 homeless youth in the City on any given day (Appendix 1.2). Most of the homeless youth live in the Tenderloin/Polk Street Area. They come from all racial and ethnic groups. Many are victims of physical and sexual abuse. 30 - 50% are sexual minorities. Many are involved in prostitution.

Yet another major identifiable group of homeless persons are homeless families. In January, 1984 over 280 homeless families with children, many of whom were infants, were sheltered at City expense in the emergency shelter hotels.

Many others are intermittently homeless. Prominent among these are the persons who rely on General Assistance ("Welfare") for support. During the 1983 calendar year 96,220 difference persons in San Francisco were supported by General Assistance. The characteristics of the persons on General Assistance place them at high risk of homelessness.





A survey of 6694 persons on General Assistance in September, 1983, conducted by the San Francisco Department of Social Services, indicated that 65% were male, 25 to 34 was the median age range, 62% were single, 16% were Veterans, 52% lived alone, 29% lived in a hotel or motel, 70% had been in San Francisco over 2 years, 7% had minor children, 56% had not completed high school, 51% had no marketable skills, 51% had never held a job for more than one year, 14% had been in jail or prison, 20% had been hospitalized in a state or county hospital, 28% had permanent physical disabilities, 24% had temporary physical disabilities, 23% had mental disabilities, 27% had applications pending for SSI, 16% had some level of alcohol abuse, 4% had some level of drug abuse, 40% had been on General Assistance two or more times during the previous two years. Unfortunately, General Assistance is a tenuous and generally inadequate source of income. The average of length of support from General Assistance is under six months. The average payment of \$248 monthly to a single person is generally insufficient to provide shelter, food, and clothing in San Francisco, where residential hotel rentals typically exceed \$260 monthly.



VII. Health Problems of the Homeless

Identify the health problems of the homeless in the service area. Explain the barriers to care that may exist. Summarize the issues in your city affecting delivery of health care services to homeless people. Attach any supporting documentation to the application as Appendix 2.

See pages 18-24

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VIII. Health Services

Describe the health services available to homeless persons in the service area. List their sources of funding, and describe their capacity and ability to serve homeless persons.

See pages 25-28



## VII. Health Problems of the Homeless

### Health Problems

The homeless in San Francisco suffer a broad range of serious medical and psychiatric problems. A survey of patients admitted to San Francisco General Hospital during the first quarter of 1983 revealed that at least 318 patients, who accounted for 7.7% of the admissions, were homeless. Of the homeless patients, 58.4% were admitted for medical or surgical problems and 41.6% were admitted for psychiatric problems (Appendix 2.1).

The medical and surgical problems of the homeless that necessitated admission included cellulitis, pneumonia, tuberculosis, chronic obstructive pulmonary disease, alcohol withdrawal, stab wounds, fractures, pancreatitis, hepatitis, and gastrointestinal bleeding. The psychiatric problems of the homeless that required hospitalization included schizophrenia, bipolar manic disorder, depression, and psychosis.

Many of the homeless patients had a high incidence of episodic and chronic problems that resulted in frequent hospitalization. Almost 40% of the patients were admitted multiple times to San Francisco General Hospital during the seventeen month period that was studied.

The homeless are frequent users of medical services. Individual interviews of 170 homeless persons at the emergency shelters in San Francisco in April, 1984 indicated that 61.2% received medical services





during the previous 3 months and 75.9% received medical services during the previous year (Appendix 2.2). These are extremely high rates of utilization for a relatively young population. Of those who used medical services, 85.3% used outpatient departments, 76.7% used emergency departments, and 30.2% were hospitalized. This is a remarkably high rate of hospitalization.

The homeless have a high incidence of previous psychiatric hospitalization. 34.7% of those interviewed stated that they had been hospitalized for psychiatric problems. Of those with a history of psychiatric hospitalization, the most recent psychiatric hospitalization for 16.9% was during the previous 6 months, for 8.5% was from 6 to 12 months prior, for 20.3% was from 1 to 3 years prior, for 23.7% was from 4 to 10 years prior, and for 30.5% was more than 10 years prior. These data suggest an impressively high incidence of severe mental illness among the homeless, as only the most severely mentally ill are hospitalized, given the substantial nationwide reduction in the availability of inpatient psychiatric services.

Despite the high incidence of major psychiatric problems among the homeless, less than 23% of those interviewed stated that they had received psychiatric services during the previous year. Of those who had received psychiatric services during the previous year, 65.8% received outpatient treatment, 28.9% received acute treatment, 13.2% received residential treatment, 10.5% received day treatment, and 5.3% received long term treatment.



A review of the records of the patients treated in the Psychiatric Emergency Service (PES) at San Francisco General Hospital revealed that, during any given period, 30% of the patients were homeless. Of the patients treated in PES three or more times in a year, 70% were shelterless on at least one visit, and 10% had no address at any time. Based on their observations at San Francisco General Hospital, Schwartz and Goldfinger have described "the new chronic patient" as "a subgroup of chronic mentally ill persons who have had little or no state hospitalization... patients are typically young, more likely to be male, and highly transient... they have frequent interactions with emergency psychiatric and crisis units, coupled with intermittent involuntary short-term stays in local inpatient units... they are typically unwilling to voluntarily accept continuing care." (Schwartz, Goldfinger, 1981)

A problem to which the homeless are especially vulnerable is sexual assault. Review of the medical records of over 350 sexual assault victims treated in 1983 at the Sexual Trauma Service in San Francisco indicated that over 9% of the treated sexual assault victims were homeless at the time of the assault. Half of the victims had injuries, ranging from major trauma such as skull fractures to minor trauma such as sprains and abrasions. All of the victims experienced some degree of psychological trauma.

The homeless also suffer a wide range of less severe medical problems. Review of the medical records of 524 homeless patients treated in 1983 at Central Emergency and 88 homeless patients treated in 1983 at a



medical clinic operated at Grace Cathedral Emergency Shelter indicated that the homeless suffer a broad range of acute problems such as infections, lacerations, upper respiratory infections, bronchitis, and cellulitis, and a wide range of chronic health problems, such as hypertension, foot problems, and dental problems (Appendix 2.3, 2.4).

At Central Emergency, 15% of the 68 homeless patients with lacerations presented more than 6 hours after the time of injury, and two-thirds of these presented more than 24 hours after the time of injury. Such delays prevented proper treatment and most of those who delayed presentation had signs of infection when they presented. Less than 30% of the homeless patients with lacerations returned to Central Emergency for follow-up wound care. With such poor follow-up, wound infections, prolonged disabilities, and other complications, which often necessitate hospitalization, are commonplace. Almost 15% of the homeless patients admitted to San Francisco General Hospital during the first quarter of 1983 were admitted because of skin infections. Many of these admissions could have been prevented had these patients received appropriate treatment earlier.

Homeless youth suffer many special medical and psychiatric problems. Review of the medical records of hundreds of homeless youth (14 to 19 years old) treated in the Adolescent Service at San Francisco General Hospital revealed a wide range of medical problems, including infections, sexually transmitted diseases, substance abuse, psychosomatic disorders, and untreated injuries, and a broad range of mental health problems, including personality disorders, acute anxiety reactions, and adjustment



reactions. Among a sample of 40 homeless youth at San Francisco General Hospital, 62.5% were depressed or exhibited self-destructive behavior, and 55% had a history of past suicide attempts.

### Barriers to Care

San Francisco is fortunate in having a wide range of medical and psychiatric services available to the homeless. Nevertheless, there are numerous obstacles that prevent homeless persons from receiving adequate health care:

#### 1. Inaccessibility of services

- difficulties of homeless patients in identifying appropriate service sites and making appointments
- long waiting times for non-emergency problems (waiting times at San Francisco General Hospital for the general medical clinic routinely exceed four weeks; waiting times in the Emergency Department for non-life-threatening problems are frequently 6 to 8 hours)
- geographic separation of San Francisco General Hospital from the Tenderloin/South of Market Area where most of the homeless live:
  1. the more seriously disabled cannot easily walk to San Francisco General Hospital and usually lack funds for public transportation
  2. attending a clinic or visiting the Emergency Department at San Francisco General Hospital frequently takes many hours, requiring those who rely on St. Anthony's Dining





Room for food to forego the only meal available to them

## 2. Inadequacy of Services to Meet the Broad Range of Medical and Psychiatric Problems of the Homeless

- lack of adequate drop-in capability at San Francisco General Hospital and South of Market Health Center for routine or minor acute medical problems, such as follow-up care, prescription refills, wound checks, and dressing changes
- inadequate psychiatric services for crisis counselling and treatment; lack of sufficient inpatient psychiatric beds, residential treatment programs, and outpatient treatment facilities

## 3. Inadequate Treatment

- hostility of professional and support staff to patients who are unkempt, abusive, mentally ill, substance abusers, and "repeaters"
- failure of professional staff, in planning treatment, to take into account problems such as the lack of shelter in which to recuperate, difficulties in safeguarding medications and following a prescribed regimen, and difficulties in caring for wounds
- inadequate follow-up care
- inadequate coordination among medical services, psychiatric services, and social services

## 4. Low Priority Given by Homeless Persons to Medical and Psychiatric Care

- lack of knowledge or understanding of their need for health services (especially common among those with serious mental disorders and with substance abuse problems)



- self-destructive behavior
- dissatisfaction with prior encounters with specific medical or psychiatric services

### Issues

The major issues affecting the delivery of health services to the homeless in San Francisco include:

- need for additional information regarding the health problems of the homeless in San Francisco
- need for better understanding of the problems in the current system of providing medical and psychiatric services to the homeless
- need to identify ways to improve medical and psychiatric services to the homeless
- inadequacy of current local, state, and federal allocations to meet the health needs of the homeless
- obtaining funds to expand existing services and to establish new services.



### VIII. Health Services

San Francisco is fortunate in having a wide range of medical and psychiatric services available in the Tenderloin/South of Market Area. Operated by or in close cooperation with the San Francisco Department of Public Health, these facilities form a comprehensive network of services that currently provide health care to many homeless persons. Nevertheless, all of these services operate at or near capacity, because of space and funding limitations, and are unable to meet the demand from the homeless for services.

St. Anthony's Clinic, operated by St. Anthony's Foundation and located adjacent to St. Anthony's Dining Room, which provides free meals to 2000 to 2500 indigent persons daily, provides comprehensive primary care for adults and children in conjunction with the broad range of other free services available on premises, including showers, delousing, clothing, laundry, shelter, and counselling. Approximately 40% of the 1400 patient visits each month are by homeless persons.

The South of Market Health Center, operated by the San Francisco Medical Center Outpatient Improvement Program, Inc., and partially funded by the San Francisco Department of Public Health, provides comprehensive primary care to adults and children. Approximately 15% of the 2200 patient visits each month are by homeless persons.

Central Emergency, operated by the San Francisco Department of Public Health and located adjacent to the Tenderloin/South of Market



Area, provides twenty-four hour a day treatment for most minor medical and surgical problems. Approximately 20% of the 2000 patient visits each month are by homeless persons.

The North of Market Multipurpose Senior Service Center, supported by the San Francisco Department of Public Health and other public and private agencies, provides comprehensive primary care to low income and frail elderly in conjunction with a broad range of other programs, including case-management, alcoholism treatment, and a food program which feeds approximately 90 elderly clients daily. Although few of the 1250 patient visits each month are by homeless persons, many of these elderly patients would likely be homeless without the services of the Center.

The Tenderloin Clinic, operated by the San Francisco Medical Center Outpatient Improvement Program, Inc. and partially funded by the San Francisco Department of Public Health, provides comprehensive outpatient mental health services to severely mentally disturbed persons living in the Tenderloin. Services include psychiatric evaluation, crisis intervention, individual and group therapy, medication monitoring, case management, and referrals. Approximately 300 clients, of whom many are homeless, are served at any given time, and approximately 60 new clients are seen each month. Approximately half of the clients are seen for over a year.

The San Francisco Department of Public Health operates a variety of mental health services in the Tenderloin/South of Market Area, including:

- the South of Market Counseling and Mental Health Outpatient Clinic,





which provides comprehensive outpatient mental health services to approximately 275 clients at any given time

- The Central City Senior's Unit, which provides comprehensive mental health services to approximately 125 persons 60 years of age and older
- the Northeast District Recidivism Team, which provides comprehensive mental health planning, counselling, and crisis intervention for severely disturbed persons who are frequent recurrent users of inpatient psychiatric services
- the Tender Lion Family Program, an outpatient, outreach mental health program for approximately 50 adults and children.

Approximately 20% of the clients treated in the various mental health programs in the Tenderloin/South of Market Area are homeless.

Other health services operated by the San Francisco Department of Public Health in the Tenderloin/South of Market Area include the City Clinic, which provides comprehensive evaluation and treatment of venereal diseases to over 4000 patients monthly, and the Sexual Trauma Service, which provides counselling and medical treatment to approximately 50 sexual assault victims monthly, of whom approximately 9% are homeless.

Although not located in the Tenderloin/South of Market Area, San Francisco General Hospital, a 582 bed acute care hospital operated by the San Francisco Department of Public Health, is the major health facility available to the homeless. Services include comprehensive emergency inpatient, and outpatient medical, surgical, and psychiatric services, with



over 80 specialty clinics. San Francisco General Hospital is the designated facility at which inpatient services are provided for all Medically Indigent Adults in San Francisco. Over 7.7% of the 1800 admissions each month are for patients who are homeless. What proportion of the 6500 monthly emergency department visits and the 16,000 monthly outpatient department visits are by homeless persons is unknown. The outpatient clinics operate at capacity and inpatient occupancy routinely exceeds 90%.



**IX. Other Services**

Describe recent major public and private efforts to meet the needs of homeless persons in your city beyond health-related concerns. List the number of shelters, residences, clothing and food programs for homeless persons and their total capacity. Attach to the application as Appendix 3 a directory of services for the homeless, if available.

See pages 30-33

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**X. Applicant Coalition**

Discuss the composition of your coalition and the nature of each member's participation. Discuss whether or not it was formed exclusively for the purpose of this grant application.

See pages 34-35



## IX. Other Services

In San Francisco, public agencies, such as the Department of Social Services, and private agencies such as the Salvation Army, the St. Vincent de Paul Society, and St. Anthony's Foundation, have a long history of helping the indigent and the homeless. In the Fall of 1982, however, because of the increasing problem of homelessness in San Francisco, private agencies reached the limit of the services that they could provide. In response, the Mayor and the Board of Supervisors joined with the private sector to provide much needed assistance to the homeless (Appendix 3.1).

In December, 1982 official City policy became to provide shelter to everyone who requested such. The Mayor established a Task Force for the Homeless, a 25 member body with representatives from all involved public and private agencies, "to identify the problems of the homeless and to develop appropriate shelter space and other services needed by that population" and the City began its Shelter for the Homeless Program with the opening of four shelters. A twenty-four hour "Housing Hotline" was established to facilitate the referral of homeless persons to the shelters. By March, 1983 over 1200 homeless persons were sheltered nightly in fourteen facilities.

Since March, 1983 the structure of the shelter program has changed and evolved. However, the City has remained committed to providing shelter to everyone who requests such. Currently, the City contracts with four agencies to provide emergency shelter for approximately 400





persons: Episcopal Sanctuary (120 beds for men/women/families), Hospitality House (80 spaces for men), St. Vincent de Paul (85 beds for men), Salvation Army (55 beds for men), and St. Anthony's (32 beds for women and youth). The City also contracts with thirteen hotels for approximately 800 persons, primarily families and single adults with serious mental and physical disabilities.

The cooperative effort between the public and private sectors that began in 1982 continues to attempt to meet the needs of the homeless. The Mayor's Task Force Shelter Providers Coalition, established in 1982 and composed of representatives of the Mayor, the Department of Public Health, the Department of Social Services, the Directors of the major shelters, and other interested agencies, meets weekly to address on-going daily problems of providing services to the homeless. The Mayor's Task Force for the Homeless meets every two to three weeks. The Central City Shelter Network, a coalition of public and private service organizations located in the Tenderloin/South of Market Area, meets monthly to discuss homeless issues.

A major effort to provide for the homeless has been the initiation of an intensified effort to provide financial assistance through General Assistance ("Welfare"). Because of this program, the General Assistance caseload has increased over 40% since December, 1982, to approximately 10,000 monthly.

Additional services available to the homeless include free food at facilities such as St. Anthony's Dining Room, which feeds approximately 2000 to 2500 persons daily, and Glide Church, which feeds approximately



2200 persons daily, free clothing through facilities such as St. Anthony's and Hospitality House, and free showers (Appendix 3.2).

Other major efforts to meet the needs of the homeless have included:

- for mentally disabled persons who have been chronically homeless, establishment of support services that include emergency shelter, money management, crisis counselling, and advocacy for General Assistance, Aid for Dependent Children, and Social Security Insurance
- the hiring of social workers for each of the four City-supported emergency shelters; social services at the shelters include needs assessment, counselling, advocacy to benefit programs, referrals for food, clothing, support services, and substance abuse programs
- A City-funded jobs program for 100 homeless persons.

Additional programs in the planning phase include:

- a cooperative program, sponsored by Hospitality House, Salvation Army, Saint Anthony's and Saint Vincent de Paul Society, to provide stable housing and support services for homeless persons (scheduled for September, 1984)
- establishment, under the auspices of the Department of Public Health, of "sober hotels" for recovering alcoholics (scheduled for January, 1985)



- construction by the Salvation Army of an Emergency Family Shelter for 50 families with children; the Shelter has been designed to include an office for medical and psychiatric treatment (scheduled for June, 1986).



## X. Applicant Coalition

Although the San Francisco Department of Public Health is not submitting this application as part of a coalition, the project that has been proposed is the result of a cooperative and collaborative effort with numerous public and private agencies that predated the announcement of the grant program.

In the planning and development of this application, the Department has met and consulted with representatives of San Francisco General Hospital, Central Emergency, Community Mental Health Services, North of Market Multipurpose Senior Service Center, South of Market Health Center, City Clinic, Saint Anthony's Clinic, and with representatives of public and private agencies, including the Mayor, Department of Social Services, Salvation Army, Saint Vincent de Paul Society, Episcopal Sanctuary, Hospitality House, San Francisco Support Services, Youth Advocates, and numerous other public and private agencies. All of these organizations unanimously supported the Department's decision to apply for a grant, as it was recognized that efforts to improve health care for the homeless should be coordinated by the Department, because the Department is the major provider of health services for the homeless and indigent in San Francisco.

A spirit of cooperation between the Department and public and private agencies has existed throughout the enormous task of assessing the medical problems of the homeless and developing plans to improve health care to





the homeless. Physicians, nurses, administrators, and others from many different programs provided valuable assistance in collecting data, conducting interviews and developing plans. Thus, the Department's proposal is the results of a consensus of the many agencies that provide services to the homeless, and is a "coalition" proposal in planning and spirit.



**XI. Governance Plan**

Describe the coalition's plan for the governance of the proposed project and for assuring that its goals are met. If a separate governing body is to be formed, indicate how it will relate to the larger coalition.

See pages 38-39

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**XII. Designated Grantee Organization**

Identify the designated 501(c)(3) organization which will receive grant funds. Indicate the authority of the designated organization to administer funds on behalf of the Coalition's project. If the designated organization is involved in activities other than this grant, explain how the governing body of the 501(c)(3) will relate organizationally and financially to the governing body of the Health Care for the Homeless Program.

The San Francisco Department of Public Health, which is submitting this application, will also receive and administer the funds that are awarded.



## XI. Governance Plan

The project will be directed by the San Francisco Department of Public Health. The Project Director will be John T. Kelly, M.D., Ph.D., who is the Medical Director of the Department's Medically Indigent Adult Program, the Medical Director of Central Emergency, Assistant Clinical Professor in the Department of Family and Community Medicine of the University of California, San Francisco, and a member of the Board of Directors of the Episcopal Sanctuary shelter. Dr. Kelly, a practicing physician and an administrator, has extensive experience in providing medical care to the homeless and planning medical services for the indigent. Placement of the project under Dr. Kelly will ensure a coordinated approach between the project and other Departmental programs for the homeless and the indigent. The Project Director will report to the Deputy Director in charge of all community health programs.

The duties of the Project Director will include:

- assure integration of the program in the Department of Public Health system
- provide direction to the Department's long-range efforts to improve health care for the homeless
- negotiate contracts or agreements with service providers
- serve as Medical Director for the nurse practitioners in the shelter clinics
- supervise ongoing collection of data regarding the medical problems of the homeless



- ongoing review of the effectiveness of the health services for the homeless.
- assure timely production of reports.

The Project Director will be assisted by two advisory bodies that are already in existence. The first is the Medical Advisory Committee, which consists of the Medical Directors of San Francisco General Hospital (Emergency, Outpatient, Adolescent, and Inpatient Services), Community Mental Health Services, North of Market Multipurpose Senior Service Center, South of Market Health Center, and Saint Anthony's Clinic. The second advisory body is the Community Advisory Committee, which consists of representatives of the Mayor and the Department of Social Services, as well as the Directors of the Salvation Army, Saint Vincent de Paul Society, Episcopal Sanctuary, Hospitality House, Saint Anthony's Foundation, San Francisco Support Services, Larkin Street Youth Center, and other community groups.

The Project Director will be assisted by a Program Development/Evaluation Specialist in the Department who will be responsible for developing the program evaluation component. The Project Director will also be assisted by clerical staff and other support personnel in the Department.





**XIII. Project Plan**

Describe in detail the principal goals and objectives of your project for providing health and casework services to homeless persons. Include the potential number of homeless persons to be served. Describe how you plan to meet these goals and objectives.

See pages 41-52



### XIII. Project Plan

#### Commitment to Health Care for the Homeless

The San Francisco Department of Public Health has, over the course of this century, been in the forefront of an ever-expanding network of health services. From model programs in vital statistics, environmental health, and other services during the early 1900's, the Department quickly expanded to include some of the country's most aggressive maternal and child health, VD, and TB programs, a model long-term care institution, as well as a major inpatient and outpatient indigent care program. As funds became available for community-based mental health services, the Department actively pursued those funds and built one of the largest county-based mental health systems in the nation. While tax problems, exacerbated by Proposition 13, and the transfer of the Medically Indigent Adult Program from the state to the counties have driven many counties to reduce or abandon their direct indigent care programs, San Francisco has maintained a position among the top in the state in its provision of medical and psychiatric services to public beneficiaries and other uncovered poor such as the homeless.

Because of its longstanding commitment to providing health care to the indigent, when the number of homeless persons in San Francisco dramatically increased in 1982, the Department played an active role in the efforts of the public and private sectors to provide essential services to the homeless.



Recent efforts of the Department to assist the homeless have include:

- active participation in the Mayor's Task Force on the Homeless
- providing advice and assistance in addressing the health problems in the shelters
- providing supplies to the shelters, such as bandages, wound-cleaning solutions, medications, and over 1000 cots
- assisting in the preparation of a "Survival Sheet for the Homeless" (Appendix 3.2)
- operating a medical clinic at Grace Cathedral Emergency Shelter (Appendix 2.4)
- providing medical supervision and supplies to student nurses from the University of San Francisco who ran nightly clinics at the four major shelters
- facilitating referrals from the shelters to Departmental facilities such as San Francisco General Hospital, Community Mental Health Services and Central Emergency
- providing the staffs at the shelters with courses on the recognition and treatment of medical and psychiatric emergencies, the management of difficult clients, and stress reduction
- establishment of on-site flu immunization programs at the drop-in centers for the homeless at the St. Vincent de Paul Society and Hospitality House
- conducting on-site tuberculosis screening at the Salvation Army.

Other important efforts of the Department have included the collection of extensive information regarding the medical problems of the homeless and their utilization of services (Appendix 2.1, 2.2, 2.3). Various



researchers in the Department have demonstrated that:

- as in other large metropolitan areas, there is a remarkably high incidence of serious physical and mental illness and substance abuse among the homeless in San Francisco
- the homeless in San Francisco are extremely heavy users of emergency, outpatient, and inpatient medical and psychiatric services
- despite heavy utilization of health services, the homeless often do not receive appropriate timely interventions and often suffer preventable serious problems and complications. The researchers, as well as others such as Francis Curry, M.D., the Director of St. Anthony's Clinic and the former Director of the San Francisco Department of Public Health, have repeatedly concluded that accessibility of services is a key factor in providing health services to this vulnerable population, and that health services for the homeless are often best provided in conjunction with other essential services such as shelter, food, counselling, and advocacy (Schwartz & Goldfinger, 1981; Kelly, 1984; Goldfinger & Chafetz, 1984; Chafetz & Goldfinger, 1984)

The Department is pleased that the Robert Wood Johnson Foundation and the Pew Memorial Trust announced the Health Care for the Homeless Program at this time because it has provided additional encouragement to existing efforts to identify and address the medical problems of the homeless. Through these efforts it has become increasingly apparent that the homeless have enormous medical and psychiatric needs that are currently not receiving adequate care or attention, and that the Department must





re-evaluate the ways in which it provides services to the homeless. A grant from the Health Care for the Homeless Program would be enormously beneficial to the Department and the homeless people of San Francisco, because it would enable the Department to provide additional direct services to the homeless, and equally important, because it would provide information and experience that would serve as the foundation for an improved system of providing medical and psychiatric services to the homeless.

### Goals and Objectives

The goals and objectives of the Department's "Sheltercare" program are to:

- increase the availability and accessibility of medical and psychiatric services for the homeless
- increase the appropriateness of the services used by the homeless for their medical and/or psychiatric problems
- increase the continuity of medical and psychiatric care for the homeless
- increase the sensitivity of professional staff to the special problems and needs of the homeless
- increase the coordination of medical and psychiatric services with other services for the homeless, including shelter, food, clothing, social services, and counselling
- generate additional information regarding the medical and psychiatric problems of the homeless in San Francisco
- test various approaches to providing medical and psychiatric care to the homeless



- identify ways to improve medical and psychiatric services to the homeless
- increase the familiarity of the various branches of the San Francisco Department of Public Health with the dimensions, causes, and implications of the health problems of the homeless
- increase the responsiveness of local, state, and federal agencies to the medical and psychiatric needs of the homeless.

### Project Plan

The Department's "Sheltercare" project will consist of two major components, one administrative and the other direct patient services.

The administrative component, under the supervision of the Project Director, will design and facilitate the implementation of medical and psychiatric services for the homeless, collect information regarding the medical and psychiatric problems of the homeless, assess the adequacy of different approaches to providing services to the homeless, and identify ways in which existing and new resources could be used to improve health services to the homeless.

The direct patient services component, established through contracts between the Department and various provider agencies, will establish medical and psychiatric clinics in various shelters and shelter hotels, expand the adult medical services at St. Anthony's Clinic, a major provider of medical and support services for the homeless, and establish a medical clinic for homeless youth at Larkin Street Youth Center, a multiservice center for



homeless youth.

## Shelter Clinics

The goal of the shelter clinics is to establish ongoing medical and psychiatric services at the major shelters for the homeless. The medical objectives of the shelter clinics are to:

- identify the medically disabled (acute, chronic) within the shelters and shelter hotels
- develop and initiate treatment plans for the medically disabled
- facilitate referrals to other facilities when appropriate (for example, San Francisco General Hospital, South of Market Health Center, Central Emergency, St. Anthony's Clinic)
- follow-up care of patients discharged from other facilities, or who are unable or refuse to visit other facilities.

The psychiatric objectives of the shelter clinics are to:

- identify the psychiatrically disabled within the shelters and shelter hotels
- provide psychiatric crisis availability to clients and staff
- develop and initiate treatment plans for the psychiatrically disabled
- provide ongoing psychiatric treatment and follow-up in clinics located within the shelters
- facilitate access to existing case management, money management, and social service advocacy existing in the shelter
- facilitate appropriate referrals to existing mental health services,



- including inpatient hospital care, residential treatment, day treatment, outpatient clinics, and recidivism services
- o provide ongoing monitoring and treatment of patients who require referral to higher levels of care but who will not accept referrals or who cannot keep appointments

### St. Anthony's Clinic

The "Sheltercare" program's goal for St. Anthony's Clinic, which is already a major provider of medical services to the homeless and indigent, is to double the hours of the adult medical clinic, so that the clinic can operate weekday afternoons in addition to weekday mornings. Existing services that will be expanded include:

- health screening and health education
- drop-in services, for attention to immediate medical problems
- comprehensive primary care, including routine laboratory evaluation and free medications
- referral to in-house specialty clinics (Chest Clinic, Podiatric Clinic, Family Clinic, Pediatric Clinic)
- consultation with and referral to appropriate secondary sources of care, including San Francisco General Hospital, South of Market Health Center, Central Emergency and Tenderloin Mental Health Clinic
- follow-up care of patients treated elsewhere, and of patients who refuse or are unable to be treated elsewhere
- referral to the broad range of other free services offered by St. Anthony's Foundation on premises, including food, shelter,





clothing, showers, delousing, laundry, employment assistance, and counselling.

#### Larkin Street Youth Center Clinic

The goal of the "Sheltercare" program for the Larkin Street Youth Center is to establish a medical clinic for homeless and street youth.

The medical services that will be provided will include:

- attention to immediate health complaints, including crisis intervention, treatment, and referral to appropriate agencies
- health assessment and screening by history, physical examination, and laboratory tests
- health education and counselling
- ongoing primary care for defined health needs
- specialized clinic hours for health problems such as sexually transmitted diseases and family planning
- consultation with and referral to appropriate secondary sources of care, including San Francisco General Hospital and other Public Health programs including those addressing alcohol and substance abuse and mental illness
- psychiatric consultation and evaluation for identified problem cases
- integration of services into the multi-service program at the Larkin Street Youth Center, which include outreach, counselling, food, clothing, shelter, and a social drop-in center.



## Case Management

As many of the patients have chronic problems, careful monitoring, or case management, is essential and will be utilized at each of the clinics. In an effort to provide services in a continuous manner, a system of tracking patients and coordinating patient care will be established. This system will consist of:

- o developing and using uniform records and forms at all service sites
- o maintaining daily logs of all patients seen at each service site
- o utilizing medical records with a comprehensive up-to-date problem list for each patient
- o using standardized referral forms for medical referrals
- o maintaining records that indicate the status and disposition of each medical and social service referral.

Although the tracking system will initially be manual, it is expected that the system can be computerized. The Department of Public Health is currently working with various providers of services to the homeless on a grant application to Apple Computer Corporation to establish a network of computers to facilitate case management. Computerization of medical and social service records will also help to provide better data to assist ongoing assessment of the needs of the homeless and monitoring of the effectiveness of services.



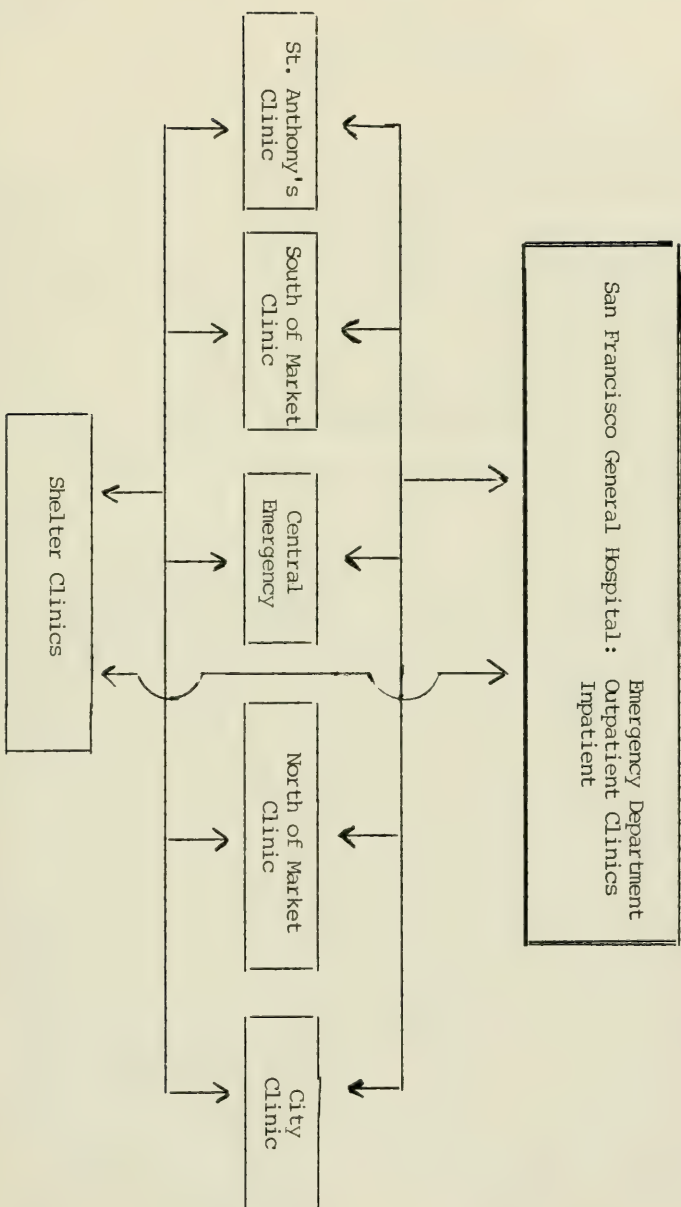
All of the sites selected for the shelter clinics have strong social service programs on premises to assist in referrals and advocacy for benefit programs such as General Assistance, Medi-Cal, food stamps, AFDC, SSI, and Veteran's benefits. St. Anthony's Foundation and the Larkin Street Youth Center also have extensive social service programs. Because of the availability of these programs on premises, the staffs of the clinics will have considerable ability to improve access to existing public benefit programs for which many homeless persons may be eligible. The coordination of health services with social services that will be possible in the clinics should greatly facilitate case management.

#### Patient Census

As a result of the clinics that will be established through the "Sheltercare" program, it is estimated that approximately 3000 different homeless persons will be treated annually at the shelter clinics, that St. Anthony's Clinic will be able to treat an additional 1000 different homeless persons annually, and that approximately 750 different homeless youth will be treated each year at the Larkin Street Youth Center Clinic



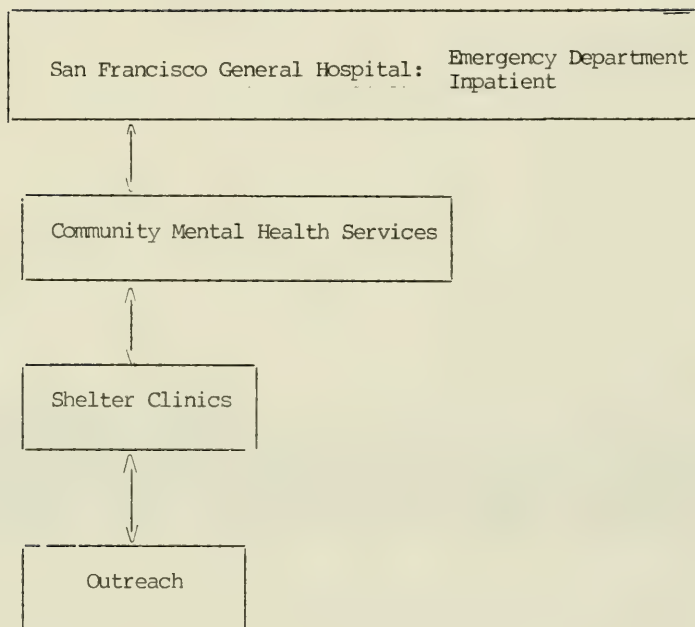
REFERRAL PATTERNS  
FOR  
MEDICAL PROBLEMS







REFERRAL PATTERNS  
FOR  
PSYCHIATRIC PROBLEMS





**XIV. Service Sites**

Identify and describe the specific service sites to be supported under this project. Explain why they have been selected. Indicate whether this proposed project represents an expansion of existing services in these locations, or the development of new services.

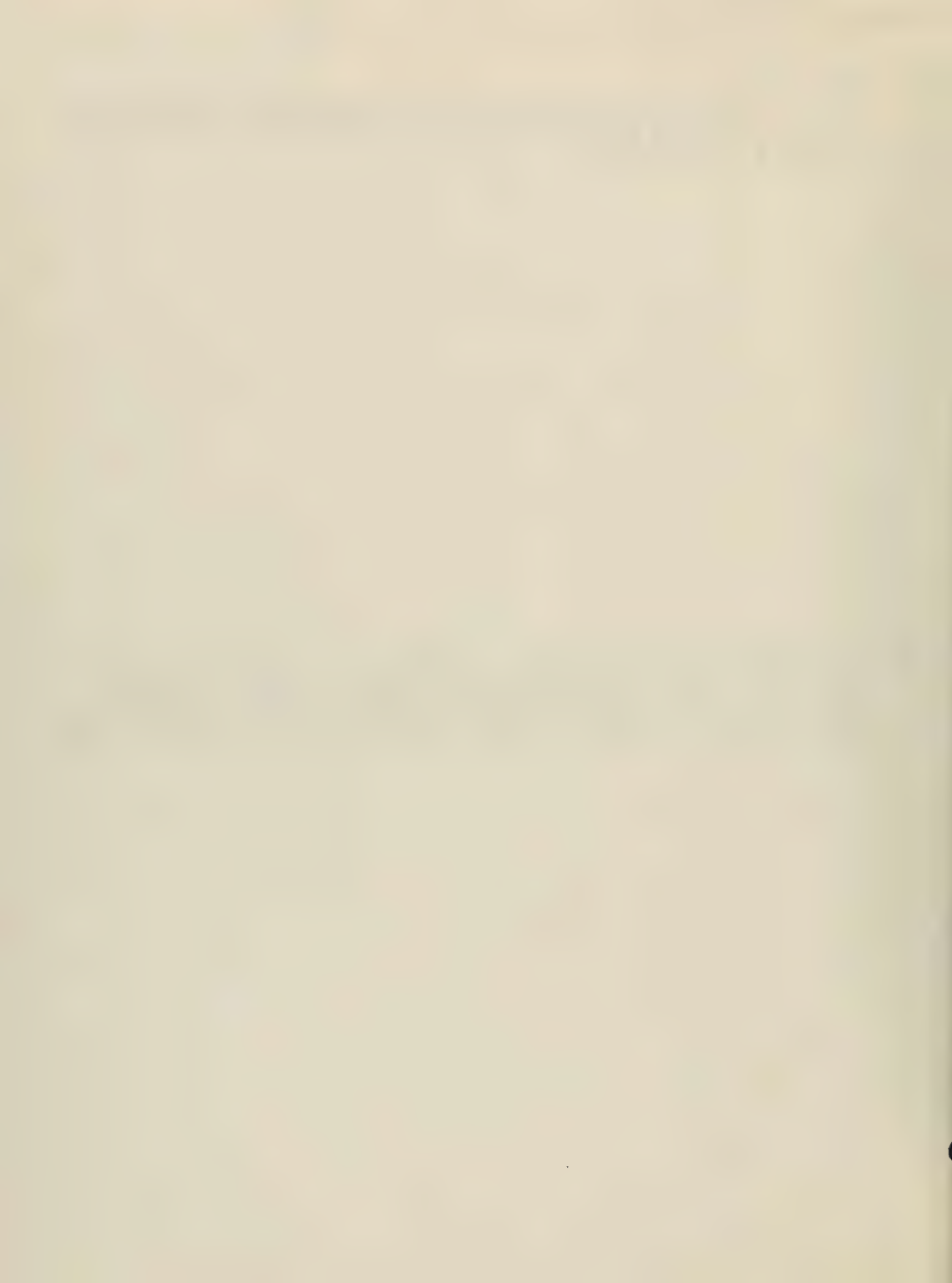
See pages 54-56

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**XV. Service Description and Schedules**

Describe the specific health and casework services which will be provided at these sites. Detail how and when they will be made available to homeless persons. Describe any outreach activities you plan to conduct in addition to the on-site services.

See pages 57-62



#### XIV. Service Sites

##### Shelter Clinics

The shelter clinic sites have been selected because they are the largest shelters and drop-in centers for the homeless, and because large numbers of homeless persons currently frequent these facilities. All of the sites are familiar and accessible to the homeless. Providing services in conjunction with services already being used by the homeless will encourage utilization of health services and will facilitate the providing of social services and case management. All of the clinical services at the shelter will be new.

The shelter clinics will be operated daily, Monday through Friday, at the St. Vincent de Paul Society and Hospitality House, and on a rotating basis several nights each week at the Salvation Army and Hospitality House.

The St. Vincent de Paul Society, a multiservice organization active in San Francisco since 1860, provides daytime hospitality and referral to over 300 clients daily, lodging to 110 persons nightly, and detoxification to 30 persons each day at its facility at 1175 Howard Street. The majority of its clients are alcoholic males.

Hospitality House, in existence since 1967, is the principal drop-in center for the Central City community. Over 300 persons each day visit the facility at 146 Leavenworth Street, which is open around the



clock. Services include recreational activities, social service referrals, free clothing, and shelter for 80 persons nightly. The clients at Hospitality House have an even larger incidence of mental illness than at the other shelters.

The Salvation Army, which has been active in San Francisco since 1880, provides a broad range of social services to the indigent and shelters 56 persons nightly at 341 Eddy Street. The Episcopal Sanctuary, located at 174 8th Street, shelters over 120 persons nightly and feeds over 370 persons daily.

#### St. Anthony's Clinic

St. Anthony's was selected because it is a major provider of medical care and other vital services, such as food, clothing, showers, laundry, counselling, and shelter, to the homeless and indigent.

St. Anthony's Clinic has provided free medical care to indigent patients in the Tenderloin area for more than twenty-five years. The Clinic is familiar and readily accessible to the homeless, many of whom eat daily at St. Anthony's Dining Room, which feeds 2000 to 2500 persons daily. The adult medical clinic, which operates weekday mornings, evaluates and treats over 700 patients each month, with approximately 35 patients at each clinic session. The adult medical clinic provides a wide range of services, including comprehensive primary care, laboratory evaluations, free medications, in-house specialty clinics (chest clinic, which treats approximately 100 patients monthly; podiatric clinic, which





treats approximately 50 patients each month), referrals for inpatient and other outpatient services, follow-up care, and coordination of medical services with the broad range of social services available through St. Anthony's Foundation.

Expansion of the hours of operation of the adult medical clinic at St. Anthony's will significantly improve the availability of medical care to the homeless.

#### Larkin Street Youth Center

The Larkin Street Youth Center, at 1040 Larkin Street, was selected because it is a multiservice program for homeless, street, and runaway youth in the Tenderloin/Polk Street neighborhood. The Center provides outreach, counselling, food, clothing, and shelter to youth, and coordinates its activities with other service organizations that work with homeless youth, including Hospitality House, Diamond Street Youth Shelter, Huckleberry House, and the Center for Special Problems Sexual Minority Youth Program.

Homeless youth have unique medical and mental health problems that can best be treated by clinicians experienced in providing services to this population. Providing health services in conjunction with the other programs at Larkin Street will greatly increase the accessibility of health services to this vulnerable population. Homeless youth are an especially important group to serve, because, with early intervention, it is likely that many of the homeless youth can be prevented from ultimately becoming impaired and homeless adults.



## XV. Service Description and Schedules

### Shelter Clinics

The clinics at St. Vincent de Paul Society and Hospitality House will operate weekdays, for four hours each day. The clinics at the Salvation Army and Episcopal Sanctuary will operate on a rotating basis, several evenings each week.

The staff of the clinics will consist of a medical director, who is also the Project Direct, 0.4 FTE psychiatrist, 1.0 FTE volunteer physicians, 2.0 FTE medical nurse practitioners, 1.0 FTE psychiatric nurse practitioners, 2.0 FTE licensed mental health workers, 2.0 FTE nurse practitioner graduate students, 1.0 FTE medical students, and 1.0 FTE nursing students. All of the salaried staff will have extensive prior experience with providing medical or psychiatric care to the homeless.

The clinic staff will work closely with the other staff at the shelters, with the goal of providing as comprehensive care as possible to meet the enormous medical, psychiatric, and other needs of this population. Case management strategies and techniques will be employed for individuals with especially high risks.

The medical services to be provided at the shelter clinics will include:

- identification of the medically disabled within the shelters



and shelter hotels:

1. receive self-referrals while the clinics are in session
  2. receive referrals from shelter workers and the staffs of the shelter hotels regarding individuals who appear to be medically disabled
  3. receive referrals from emergency, outpatient, and inpatient services
  4. develop ongoing, trusting relationships with clients, shelters, and referral agencies
- development and initiation of treatment plans for the medically disabled:
    1. identify acute and chronic medical conditions
    2. treatment of acute and chronic problems
    3. facilitate access to existing case management, money management, and social service advocacy existing in the shelters
    4. make referrals to other medical facilities when appropriate
    5. follow-up care of patients discharged from other facilities, or who are unable or refuse to visit other facilities
  - development of preventive measures:
    1. conduct health screening for conditions such as hypertension, diabetes, substance abuse, and tuberculosis
    2. provide immunization such as tetanus, influenza, and Pneumovax



The psychiatric services to be provided will include:

- identification of the psychiatrically disabled within the shelters and shelter hotels:
  1. receive self-referrals while the clinics are in session
  2. receive referrals from shelter workers and the staffs of the shelter hotels regarding individuals who appear to be mentally disabled
  3. receive referrals from the psychiatric emergency, outpatient, and inpatient services
  4. provide outreach services to the mentally ill
  5. develop ongoing trusting relationships with clients, staff, and referral agencies
- providing psychiatric crisis availability to clients and staff
- development and initiation of treatment plans for the psychiatrically disabled:
  1. assess mental status and diagnose existing psychiatric problems
  2. establish and initiate a treatment plan, including plans for medications
  3. establish a therapeutic relationship and develop rapport
- providing ongoing psychiatric treatment and follow-up in clinics located within the shelters:
  1. provide ongoing medication monitoring
  2. provide continuity of therapeutic relationship
  3. provide limited case management services necessary in





maintain treatment and make appropriate referrals

- facilitating appropriate referrals to existing mental health services, including inpatient hospital care, residential treatment, day treatment, outpatient clinics, and recidivism services
- providing ongoing monitoring and treatment of patients who require referral to higher levels of care but who will not accept referrals or who cannot keep appointments
- development and initiation of preventive measures:
  1. identify clients with emerging problems that can be prevented
  2. provide instruction to the shelter staff on the identification and management of mental health problems
  3. facilitate stress reduction among clients and staff.

#### St. Anthony's Clinic

St. Anthony's adult medical clinic will be expanded from its current schedule of operating weekday mornings to a schedule in which it will be open mornings and afternoons every weekday. The afternoon clinic will be staffed with 0.5 FTE physician, 0.2 resident physician, and 1.0 FTE nurse coverage.

Services in the adult medical clinic will include:

- health screening and health education
- drop-in services, for attention to immediate medical problems
- comprehensive primary care, including routine laboratory



evaluation and free medications

- referral to in-house specialty clinics
- consultation with and referral to appropriate secondary sources of care
- follow-up care of patients treated elsewhere, and of patients who refuse or are unable to be treated elsewhere
- referral to the broad range of other free services offered by St. Anthony's Foundation on premises, including food, shelter, clothing, shower, delousing, laundry, employment assistance, and counselling.

#### Larking Street Youth Center Clinic

The clinic at Larkin Youth Center, which will operate weekday evenings, will be staffed by 0.5 FTE nurse practitioner and 0.2 FTE physician, each of whom will have extensive experience in adolescent medicine. The medical services that will be available will include:

- attention to immediate health complaints, including crisis intervention, treatment, and referral to appropriate agencies
- health assessment and screening by history, physical examination, and laboratory tests
- health education and counselling
- ongoing primary care for defined health needs
- specialized clinic hours for health problems such as sexually transmitted diseases and family planning
- consultation with and referral to appropriate secondary sources of care, including those addressing alcohol and substance abuse



- psychiatric consultation and evaluation for identified problem cases
- integration of services into the multi-service program at the Larkin Street Youth Center, which includes outreach, counselling, food, clothing, shelter, and a social drop-in



**XVI. Personnel**

Describe the types of personnel which will give these services. Describe the functions of the project director and each member of the health service team. Attach to the application as Appendix 4 job descriptions for key personnel in the project.

See pages 64-66

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**XVII. Staff Burn-out**

Describe your plans to protect staff from work frustration and burn-out.

See pages 67





## XVI. Personnel

The shelter clinics will include a medical director, a supervising psychiatrist, volunteer physicians, medical and psychiatric nurse practitioners, licensed mental health workers, nurse practitioner trainees, medical students, and nursing students. This staffing pattern, which relies heavily on non-physician and voluntary personnel, was adopted because it was judged to be a cost-effective means of providing services. All salaried staff will have extensive experience in providing medical or psychiatric services to the homeless.

The medical director, who is also the Project Director, will design the clinics, establish policies and procedures, and supervise the volunteer physicians, medical nurse practitioners, and supervising psychiatrist. The supervising psychiatrist will supervise the mental health component of the clinics, which includes psychiatric nurse practitioners, psychiatric nurse practitioner trainees, and licensed mental health workers. All of the staff will provide direct patient services.

At St. Anthony's Clinic, the personnel supported by the grant program will include a physician, a medical resident and registered nurses. All of these staff will provide direct patient services, under the supervision of the Medical Director of the Clinic, according to existing policies and procedures.

At the Larkin Street Youth Center Clinic, the staff will consist

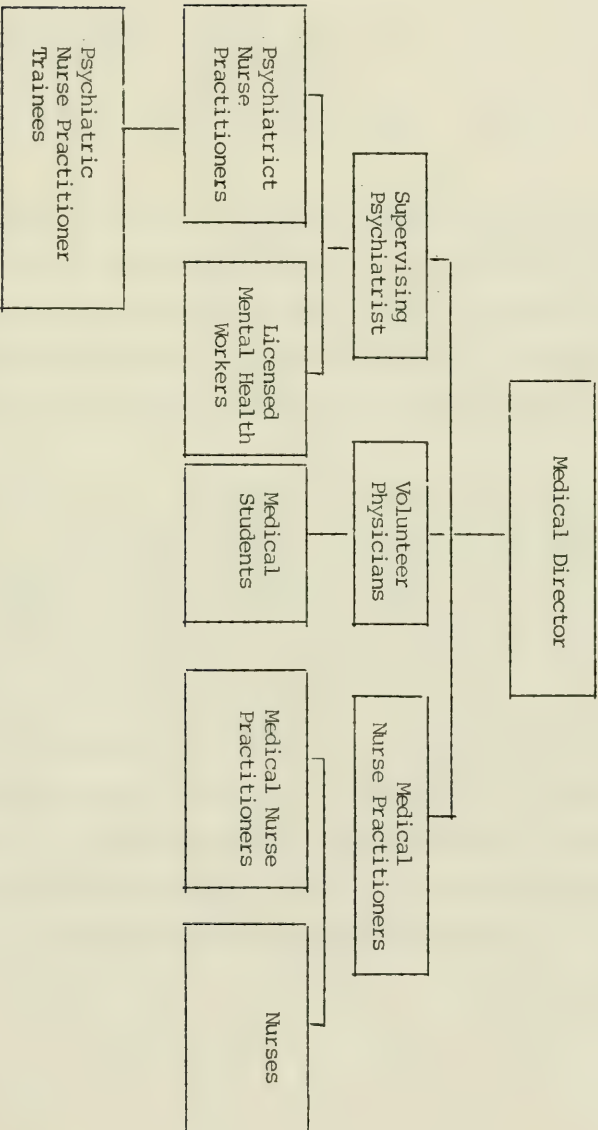


of a physician and a nurse practitioner, each of whom have training in adolescent health and extensive experience in caring for homeless youth. The physician, with the assistance of the nurse practitioner, will design the clinic, establish policies and procedures, and prepare protocols for the nurse practitioner. The physician and the nurse practitioner will both provide direct patient services.

Ancillary personnel, such as social workers and clerical staff, are not being funded through this grant because all of the clinic sites already have such staff and will make them available to the clinics without cost to the program.



Shelter Clinics  
Supervisory Structure





## XVII. Staff Burn-Out

Although there is a high risk of work frustration and burn-out in providing services to the homeless, the risks can be minimized by careful selection of staff and ongoing support efforts for the staff.

As much as possible, the staff should have prior experience in working with the homeless and should have a clear understanding of the problems associated with providing services to this population. San Francisco is fortunate in having many capable professionals with extensive experience in and commitment to working with the homeless.

Support efforts for the staff should include thorough orientation, weekly or biweekly staff meetings to discuss issues regarding the program and problems with individual clients, involvement of the staff in decision-making, and ongoing in-service training programs.

The Department of Public Health recently presented a program for the shelter providers on mental health problems and stress reduction (Appendix 7). The program taught information and techniques that should help reduce work frustration and burn-out. This program can service as a model for future in-service training.





**XVIII. Participating Organizations**

Identify the specific hospitals, health centers, and agencies which will participate in this project. Explain why they have been selected. Attach to the application as Appendix 5 a letter of agreement from each of these participants confirming their involvement and specifically describing their function and responsibilities. Attach as Appendix 6 a diagram showing the formal relationships between the relevant parties involved. Include the coalition, governing body and service sites.

See pages 69-70

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**XIX. Continued Support**

Explain the Coalition's general plan and expectations for sustaining services beyond the four-year project period. [Funding for the second 24-month period will be contingent upon an evaluation of performance by the Program staff and National Advisory Committee, as well as a review of the coalition's plan and progress towards sustaining services, in whole or in part, beyond the four-year period of support.]

See page 71



## XVIII. Participating Organizations

The governing body and the service sites that will participate in this project have been described fully in Sections XI, XIII, and XIV. Appendix 5 contains letters of agreement from each of the participating agencies. Appendix 6 shows the formal relationships between the relevant organizations.

All of the service sites will have ready access to a wide variety of Department-funded agencies, such as San Francisco General Hospital, Community Mental Health Services, Central Emergency, North of Market Multipurpose Senior Service Center, and South of Market Health Center. County policy in San Francisco is that all health services for medically indigent adults are provided by the Department of Public Health at Department-funded facilities. Access to these services is available to everyone, regardless of ability to pay. Consequently, formal letters of agreement from the hospitals and health centers which will be an integral part of the comprehensive services provided through the program are not necessary.

All of the services supported by the grant will be provided through contracts. The services at St. Anthony's Clinic will be provided through contract with the St. Anthony's Foundation. The services at the shelter clinics and the Larkin Street Youth Center will also be provided through contracts. Several agencies, including the San Francisco Medical Center Outpatient Improvement Corporation, have expressed



strong interest in contracting with the Department to provide these services. However, because the Department is currently conducting a major review of the agencies through which all contractual services are provided, the specific agency with which the Department will contract for the shelter clinics has not been selected.



## XIX. Continued Support

The Department of Public Health recognizes that current services for the homeless are inadequate to meet their needs for health care. Representatives of the Mayor and the Board of Supervisors are also keenly sensitive to the health needs of the homeless.

The Department expects that the proposed project will provide:

- o crucial information regarding the medical problems and needs of the homeless
- o opportunities for ongoing review of the relative effectiveness of different strategies for providing health care to the homeless
- o much needed direction to the Department's long range efforts to improve health care for the homeless.

The Department has a large professional staff and substantial discretionary revenue that provides it with considerable flexibility in redirecting its resources to the project. The Department also expects that resources to augment the funds received from the grant will become available before the end of the four-year period of support and that the City will provide continued support beyond the end of the four-year period to the Department's effort to expand medical services to the homeless.





**XX. Governance, Planning, and Oversight Activities**

Over the 4-year grant period, up to \$200,000 may be sought for activities related to planning, governance and oversight. If you intend to seek these funds under this grant, describe how you intend to use them, and how this use will complement the health care project. Refer to Budget, Section XXIV, for a description of these activities.

See page 75

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**XXI. Specific Considerations**

Specifically describe how and to what extent you are addressing each of the following points, if not already discussed.

- The potential number of homeless persons to be served under your project.

See XIII.

- 
- The ability at the project sites to provide health services in a continuous manner to a known population of homeless persons.

See XIII.



## XX. Governance, Planning, and Oversight Activities

The Department of Public Health is requesting no funds for activities related to planning, governance, and oversight. With the exception of unavoidable overhead expenses and travel funds for the Project Director, all of the resources received from the Program will be used for providing direct patient services. This approach, which takes advantage of the administrative resources of the Department and its capability of providing in-kind contributions of personnel, allows as much of the grant as possible to be used in providing the on-site services that are so keenly needed by the homeless.



- 
- . The ability to improve access to existing public benefit programs for which homeless persons may be eligible (e.g. SSI, Medicaid, Veteran's benefits).

See XIII.

- 
- The commitment of other not previously available state, local and private funds and resources to meet the basic needs of the homeless at the sites funded under this program (e.g. food, shelter, employment assistance), or to develop additional health service sites.

See XIX.

- 
- The ability to assure access to additional health and other services needed by homeless persons that are not available at the sites (for example, referrals to local public health agencies dealing with communicable diseases and to alcohol and drug abuse programs).

See XIII.



- The active involvement and participation of local and state governments.

See III, IX, Appendix 3.1

- 
- The active involvement and participation of hospitals in developing and administering service projects.

See X.

- 
- The establishment of arrangements for inpatient hospital care for persons referred by the clinic sites.

See XIII, XVIII, Appendix 6.





XXII. Work Plan

Include a timetable for implementation of the project objectives. It should describe actual activities that we can see at specific times during the grant period and that represent progress toward attainment of your objectives.

See page 77



## XXII. Work Plan

1984

July-September	Continuation of intensive planning Negotiation of contracts to provide health services
October-December	Design services Recruit staff

1985

January-February	Hire staff Begin health services at all sites
March-	Ongoing monitoring of programs, introduction of changes as appropriate, continuation of long-range planning efforts on health care for the homeless
	Completion of report on the Department of Public Health's long-range plans to provide health care to the homeless

1986

January-February	Budget request to City to augment medical services funded by the Program
July-	With City funds, expand services for the homeless, including expanded case management

1987

February-	Budget request to City for additional resources to provide medical services for the homeless
July-	With City funds, expand services for the homeless

1988

February-	Budget request to City to provide support for activities previously funded by the Program
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XXIII. Map


Mark the boundaries of the service delivery area of your project on a map. Locate and identify the participating service delivery sites, hospitals, organizations, and agencies on the map. Reduce the map to fit on this page.


See page 79




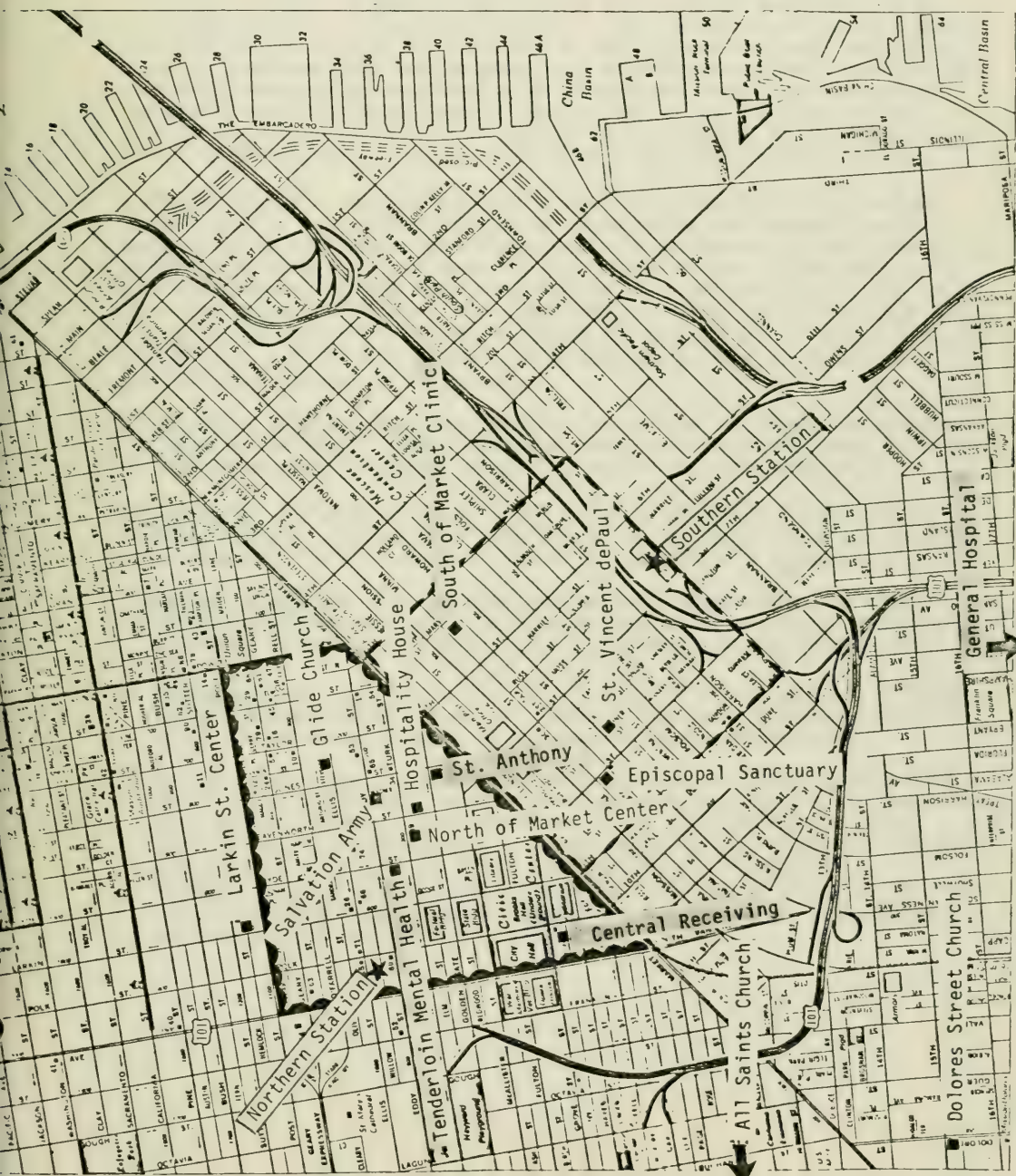
KEY

- ☐ Health Services
- ☐ Shelter
- ☐ Youth Services
- ☐ Food, only
- ☐ Senior Services

 Tenderloin Area

 South of Market Area

 District Police Station







**XXIV. Budget**

The budget included in the application indicates the format in which costs associated with the program should be identified. Use the form of the budget in the application as a model for each year's funding. Include a separate form for each of the four years. Applicants will be eligible for grants of up to a total of \$1.4 million each over four years. Up to \$200,000 of that amount may be used to support the planning and oversight activities of the city-wide coalition and project governing body. These activities may include coordination, monitoring and oversight of the city-wide project; developing surveys, needs analysis, action plans, and resource materials; organizing conferences, seminars, and meetings to study homeless issues; development and implementation of plans to sustain services beyond the four-year project period. The balance of the grant must be used to support the delivery of services. (Alternatively, all funds can be used for direct service delivery.)

Although there will be only a single application process for this program, funding will be in two 24-month cycles. Funding for the second 24-month period will be contingent upon an evaluation of performance by the Program staff and National Advisory Committee, as well as review of the coalition's plan and progress towards sustaining services, in whole or in part, beyond the four-year period of support. The budget section of the application must also include a "budget narrative" which relates the cost factors to the programmatic activities. The following guidelines include those items to be explained in the narrative portion of the budget.

- A) Personnel & Fringe Benefits: Please list by name (if known) and/or program title in the budget. The project functions and responsibilities for which support is being requested should be described in the narrative.
- B) Supplies: All administrative items should be presented and explained in this category. The basis for computation of the items listed should also be included. Medical supplies should be itemized in a separate list.
- C) Office Operations: The projected expenditures for printing and duplicating, telephone, postage, and computer costs, if applicable, should be provided, as well as the method used to determine each of these items.
- D) Transportation: Estimated local travel expenses in transporting homeless persons between project sites and other service centers in attainment of health delivery goals should be detailed in the budget narrative.
- E) Project Staff Travel: Estimated travel expenses (including local travel) should be shown for each program staff member as well as a brief justification for the request. Local travel allowance is to be based on the grantee's current cost formula. Include costs for two representatives from your project to attend the yearly national meeting @ \$780/person. Attendance at any two professional meetings that relate to the Health Care for the Homeless Program can be budgeted in the line item. Two meetings per year at \$880 per meeting are allowable.



- F) Consultant Travel: The travel costs and per diem should be shown in detail for each consultant.
- G) Indirect Costs: This line is calculated as follows:
- 1) Space not included as a separate line item — 9% of items A) through F).
  - 2) Space included as a separate line item — 4% of items A) through F).  
See line J) for calculation of space rental.
- H) Consultant Honoraria: The fees are not to exceed \$200 per day for a consultant. The balance of any fee that exceeds \$200 per day must be funded through resources other than grant funds.
- I) Equipment: A limited amount of equipment can be shown in the budget. The narrative should contain a full justification of need for said equipment.
- J) Space Rental: If included, this figure should represent 5% of total salaries plus fringe benefits. Since this is not considered a direct cost, overhead should not be calculated on this line item.

Total Yearly Budget: The sum of all lines A) through J).

Any subcontract to be supported on this grant needs to be submitted to both the program staff and Foundations for review.

Non-Allowable Expenses: Grant funds may not be used:

- 1) To renovate or alter existing facilities.
- 2) To construct new facilities.
- 3) As a substitute for funds currently being used to support similar activities.
- 4) To reduce on-going deficits for pre-existing operations.
- 5) As a recurring revenue (and, therefore, as a reduction of third-party reimbursement).



#### XXIV. Budget

##### A. Administrative/Planning

During the planning period from July through December, 1984, and throughout the four-year duration of the Program, the salaries and fringe benefits of the Project Director/Medical Director, Health Program Planner, and Clerk Typist, as well as the costs of administrative supplies and office operations, will be supported by the San Francisco Department of Public Health, without cost to the Foundation.

The only administrative costs to be borne by the Foundation will be the expenses for two representatives of the Program to attend the yearly national meeting (@ \$780/person) and the expenses to attend annually two professional meetings that relate to the Health Care for the Homeless Program (@ \$880/person.)

##### B. Health Service Delivery

###### Grant Year 1

###### Clerk Typists

The salaries of 0.25 FTE clerk typists at four sites, St. Vincent de Paul Society, Hospitality House, St. Anthony's Clinic, and Larkin Street Youth Center, will be provided as "in-kind" contributions by each of these agencies, without cost to the Foundation.



### Physicians

The salaries of 0.4 FTE physician at the shelter clinics, 0.5 FTE physician at St. Anthony's Clinic, and 0.2 FTE physician at Larkin Street Youth Center Clinic will be supported by the Foundation. The salaries of 1.0 FTE physicians at the shelter clinics will be supported as "in-kind" contributions by the San Francisco Department of Public Health.

### Nurse Practitioners

The salaries of 3.0 FTE nurse practitioners at the shelter clinics and 0.5 FTE nurse practitioner at Larkin Street Youth Center Clinic will be supported by the Foundation.

### Nurse

The salaries of 1.0 FTE nurse at St. Anthony's Clinic will be supported by the Foundation.

### Supervising Clinicians

The salaries of 2.0 FTE supervising clinicians (licensed mental health workers) at the shelter clinics will be supported by the Foundation.

### Resident Physician

The salary of 0.2 FTE resident physician at St. Anthony's Clinic will be supported by the Foundation.





#### Graduate Student Nurses

Stipends for 2.0 FTE graduate student nurses (nurse practitioner trainees) at the shelter clinics will be supported by the Foundation.

#### Fringe Benefits

Fringe benefits for employees of the San Francisco Department of Public Health are 27%. Fringe benefits of employees supported through contract are 17%. All of the employees at the Health Service Delivery sites supported by the Foundation will be hired on a contractual basis, and will receive fringe benefits of 17%.

#### Medical Supplies

During the first year of the grant program, resources from the Foundation will be used to contribute to the purchase of equipment such as otoscope/ophthalmoscopes (5 sets) sphygmomanometers (5), and basins, and supplies such as medications and dressings. During the second through fourth years of the grant program, medical equipment and supplies will be provided as "in-kind" contributions from the San Francisco Department of Public Health and St. Anthony's Clinic.

#### Administrative/Office Supplies

Office supplies as well as printing and mailing costs will be provided as "in-kind" contributions by the



San Francisco Department of Public Health and by the agencies operating each of the clinics.

#### Indirect Costs

The City and County of San Francisco assesses a 2% fee on all grants recieved by municipal agencies, including the Department of Public Health. A contractor's fee of 9% is assessed by the agencies with which the Department of Public Health will contract to provide services. Thus, indirect costs will total 11%.

#### Grant Years 2-4

Services supported by the Foundation during the second through fourth years of the grant will be the same as during the first year, with the exception that medical supplies and the salary of the resident physician at St. Anthony's Clinic will be provided by the San Francisco Department of Public Health. An annual inflation factor of 5% was used to calculate expenses.



GRANTEE: S.F. Department of Public Health GRANT PERIOD: (from 1/85 to 12/88)  
BUDGET PERIOD: (from 7/84 to 12/84) GRANT YEAR: 1 2 3 4 (circle one) p.86

[illegible]



GRANTEE: S.F. Department of Public Health GRANT PERIOD: (from 1/85 to 13/88)  
 BUDGET PERIOD: (from 1/85 to 12/85) GRANT YEAR: (1) 2 3 4 (circle one) p.87

A. PERSONNEL		HEALTH SERVICE DELIVERY		COALITION PLANNING OVERSIGHT	
(list name and title)	% time	Foundation	Other Support	Foundation	Other Support
Project Director/Medical Director	0.5				34,725
Health Program Planner	0.5				16,940
Clerk Typist	1.5		18,295		9,155
Physician	2.1	65,620	59,655		
Nurse Practitioner	3.5	95,930			
Nurse	1.0	24,920			
Supervising Clinician	2.0	47,670			
Resident Physician	0.2	5,320			
Graduate Student Nurses	2.0	10,000			
FRINGE BENEFITS <sup>a</sup> (17%) <sup>b</sup> (27%)		<sup>a</sup> 42,405	<sup>a</sup> 13,250		<sup>b</sup> 16,420
SUBTOTAL PERSONNEL:		291,865	91,200		77,245
B. SUPPLIES					
Medical		5,000	20,500		
Administrative/Office			5,125		5,125
C. OFFICE OPERATIONS(detailed in narrative)					
D. TRANSPORTATION					
E. PROJECT STAFF TRAVEL					
Annual Meeting				1,560	
Professional Meeting				1,760	
Local Travel					
F. CONSULTANT TRAVEL & PER DIEM					
G. INDIRECT COSTS (A-F)		37,605		66	
H. CONSULTANT HONORARIA					
I. EQUIPMENT					
J. SPACE RENTAL					
TOTAL YEARLY BUDGET:		329,470	116,825	3,386	82,370
TOTAL FOUNDATION PORTION: (YR)		73.8%		3.9%	
TOTAL FOUNDATION "2" YRS.		669,642		6,772	
TOTAL FOUNDATION "4" YRS.		1,386,237		13,544	





GRANTEE: S.F. Department of Public Health GRANT PERIOD: (from 1/85 to 12/88)  
 BUDGET PERIOD: (from 1/86 to 12/86) GRANT YEAR: 1 (2) 3 4 (circle one) p.88

A. PERSONNEL	(list name and title)	% time	HEALTH SERVICE DELIVERY		COALITION PLANNING OVERSIGHT	
			Foundation	Other Support	Foundation	Other Support
	Project Director/Medical Director	0.5				36,460
	Health Program Planner	0.5				17,790
	Clerk Typist	1.5		19,210		9,615
	Physician	2.1	68,901	62,640		
	Nurse Practitioner	3.5	100,725			
	Nurse	1.0	26,165			
	Supervising Clinician	2.0	50,055			
	Resident Physician	0.2	5,585			
	Graduate Student Nurses	2.0	10,500			
	FRINGE BENEFITS (17%) <sup>a</sup> (27%) <sup>b</sup>		44,530 <sup>a</sup>	13,915 <sup>a</sup>		17,245 <sup>b</sup>
	SUBTOTAL PERSONNEL:		306,461	95,765		81,110
B. SUPPLIES						
	Medical			21,525		
	Administrative/Office			5,380		5,380
C. OFFICE OPERATIONS(detailed in narrative)						
D. TRANSPORTATION						
E. PROJECT STAFF TRAVEL						
	Annual Meeting				1,560	
	Professional Meeting				1,76	
	Local Travel					
F. CONSULTANT TRAVEL & PER DIEM						
	G. INDIRECT COSTS (A-F)		33,711		66	
H. CONSULTANT HONORARIA						
I. EQUIPMENT						
J. SPACE RENTAL						
	TOTAL YEARLY BUDGET:		340,172	122,670	3,386	86,490
	TOTAL FOUNDATION PORTION: (YR)		73.5%		3.8%	
	TOTAL FOUNDATION "2" YRS.		669,642		6,772	
	TOTAL FOUNDATION "4" YRS.		1,386,237		13,544	



A. PERSONNEL	(list name and title)	% time	HEALTH SERVICE DELIVERY		COALITION PLANNING OVERSIGHT	
			Foundation	Other Support	Foundation	Other Support
	Project Director/Medical Director	0.5				38,283
	Health Program Planner	0.5				18,680
	Clerk Typist	1.5		20,170		10,095
	Physician	2.1	72,345	65,770		
	Nurse Practitioner	3.5	105,760			
	Nurse	1.0	27,470			
	Supervising Clinician	2.0	52,560			
	Resident Physician	0.2		5,865		
	Graduate Student Nurses	2.0	11,025			
	FRINGE BENEFITS ( <sup>a</sup> 17%) ( <sup>b</sup> 27%)		45,757 <sup>a</sup>	15,607 <sup>a</sup>		18,105 <sup>b</sup>
	SUBTOTAL PERSONNEL:		314,917	107,412		85,163
B. SUPPLIES						
	Medical			22,600		
	Administrative/Office			5,650		5,650
C. OFFICE OPERATIONS(detailed in narrative)						
D. TRANSPORTATION						
E. PROJECT STAFF TRAVEL						
	Annual Meeting				1,560	
	Professional Meeting				1,760	
	Local Travel					
F. CONSULTANT TRAVEL & PER DIEM						
	G. INDIRECT COSTS (A-F)		34,640		66	
H. CONSULTANT HONORARIA						
I. EQUIPMENT						
J. SPACE RENTAL						
	TOTAL YEARLY BUDGET:		349,557	135,662	3,386	90,813
	TOTAL FOUNDATION PORTION: (YR)		72.0%		3.6%	
	TOTAL FOUNDATION "2" YRS.		669,642		6,772	
	TOTAL FOUNDATION "4" YRS.		1,386,237		13,544	



BUDGET PERIOD: (from 1/88 to 12/88 ) GRANT YEAR: 1 2 3 (4) (circle one) p. 9

A. PERSONNEL	(list name and title)	% time	HEALTH SERVICE DELIVERY		COALITION PLANNING OVERSIGHT	
			Foundation	Other Support	Foundation	Other Support
	Project Director/Medical Director	0.5				40,198
	Health Program Planner	0.5				19,614
	Clerk Typist	1.5		21,180		10,600
	Physician	2.1	75,960	69,060		
	Nurse Practitioner	3.5	111,050			
	Nurse	1.0	28,845			
	Supervising Clinician	2.0	55,190			
	Resident Physician	0.2		6,160		
	Graduate Student Nurses	2.0	11,575			
	FRINGE BENEFITS ( 17% ) ( 27% )		48,045 <sup>a</sup>	16,388 <sup>a</sup>		19,011 <sup>b</sup>
	SUBTOTAL PERSONNEL:		330,665	112,788		89,423
B. SUPPLIES						
	Medical			23,730		
	Administrative/Office			5,935		5,930
C. OFFICE OPERATIONS(detailed in narrative)						
D. TRANSPORTATION						
E. PROJECT STAFF TRAVEL						
	Annual Meeting				1,560	
	Professional Meeting				1,760	
	Local Travel					
F. CONSULTANT TRAVEL & PER DIEM						
G. INDIRECT COSTS (A-F)			36,373		66	
H. CONSULTANT HONORARIA						
I. EQUIPMENT						
J. SPACE RENTAL						
TOTAL YEARLY BUDGET:			367,038	142,453	3,386	95,35
TOTAL FOUNDATION PORTION: (YR)			72.0%		3.4%	
TOTAL FOUNDATION "2" YRS.			669,642		6,772	
TOTAL FOUNDATION "4" YRS.			1,386,237		13,544	





## XXV. Complete this checklist:

- ☒ Application (20 copies)
- ☒ Additional non-attached copies of abstract (20 additional copies)
- ☐ One copy of each of the necessary IRS tax-exempt letters
- ☒ Request for Project Support and Conditions of Grant Form (original copy, please)





A p p e n d i c e s



# Appendix 1.1

## Characteristics of Residents of Emergency Shelters Compiled of San Francisco Department of Social Services

I. October 5-6, 1983 (N=329)

<u>Age</u>	<u>Number</u>	<u>Percent</u>	<u>Residence</u>	<u>Number</u>	<u>Percent</u>
Under 18	0	0%	0-3 months	120	36%
18-24	36	11%	4-6 months	37	11%
25-30	61	19%	7-11 months	24	7%
31-35	64	19%	1-2 years	39	12%
36-39	36	11%	2+ years	104	32%
40-49	51	16%	Unknown	5	2%
50+	45	13%			
Unknown	36	11%	<u>Marital Status</u>		
			Single	237	72%
<u>Sex</u>			Married	25	7%
Male	301	91%	Widowed	11	3%
Female	28	9%	Divorced/Separated	51	16%
			Unknown	5	2%
<u>Ethnicity</u>			<u>Education</u>		
White	170	52%	None	10	3%
Black	90	27%	Elementary	52	16%
Hispanic	36	11%	High School	182	55%
Asian	6	2%	College Degree	59	18%
American Indian	7	2%	Trade/Business School	23	7%
Other	13	4%	Unknown	3	1%
Unknown	7	2%			



<u>Physical Disability</u>	<u>Number</u>	<u>Percent</u>
None	224	68%
Temporary	42	13%
Permanent	57	17%
Unknown	6	2%

<u>Mental Disability</u>		
Yes	36	11%
No	249	76%
Unknown	44	13%

<u>Drug Abuse</u>		
None	261	79%
Occasional	33	10%
Moderate	16	5%
Addicted	12	4%
Unknown	7	2%

<u>Alcohol Abuse</u>		
None	222	67%
Occasional	42	13%
Moderate	26	8%
Severe	27	8%
Unknown	12	4%

<u>Marketable Skills</u>	<u>Number</u>	<u>Percent</u>
Yes	228	69%
No	82	25%
Unknown	19	6%

<u>Employment History</u>		
None	18	5%
Part Time	37	11%
Short Term	25	8%
1 + years	236	72%
Unknown	13	4%

<u>Means of Support</u>		
Job	19	6%
GA	41	12%
Food Stamps	22	1%
SSI	19	6%
Medi-Cal	1	0%
AFDC	1	0%
Other	33	10%
None	186	57%
Unknown	7	2%



II. November 7-8, 1983 (N=333)

<u>Age</u>	<u>Number</u>	<u>Percent</u>
18-20	10	3%
21-24	38	11%
25-29	58	17%
30-34	65	20%
35-39	40	12%
40-44	32	10%
45-49	23	7%
50-54	19	6%
55 +	34	10%
Unknown	14	4%

Sex

Male	313	94%
Female	21	6%

Ethnicity

White	178	53%
Black	83	25%
Hispanic	42	13%
Asian	4	1%
American Indian	10	3%
Other	13	4%
Unknown	3	1%

Residence

0-3 months	109	33%
4-6 months	38	11%
7-11 months	16	5%
1-2 years	29	9%
2 + years	135	40%
Unknown	6	2%

<u>Marital Status</u>	<u>Number</u>	<u>Percent</u>
Single	231	69%
Married	22	7%
Widowed	13	4%
Divorced/Separated	63	19%
Unknown	4	1%

Education

None	3	1%
Elementary	58	17%
High School	189	57%
College Degree	55	17%
Trade School	17	5%
Current College	3	1%
Unknown	8	2%

Physical Disability

None	229	69%
Temporary	38	11%
Permanent	55	17%
Unknown	11	3%

Mental Disability

Yes	40	12%
No	259	78%
Unknown	34	10%

Drug Abuse

None	254	76%
Occasional	24	7%
Moderate	19	6%
Addicted	20	61%
Unknown	16	5%





<u>Alcohol Abuse</u>	<u>Number</u>	<u>Percent</u>	<u>Veteran Status</u>	<u>Number</u>	<u>Percent</u>
None	179	54%	Yes	119	36%
Occasional	54	16%	No	206	62%
Moderate	37	11%	Unknown	8	2%
Severe	53	16%			
Unknown	10	3%			

#### Marketable Skills

Yes	228	68%
No	92	28%
Unknown	13	4%

#### Employment History

None	25	8%
Part Time	34	10%
Short Time	30	9%
1 + years	234	70%
Unknown	10	3%

#### Means of Support

Job	17	5%
GA	33	10%
SSI	15	4%
SSA	6	2%
UIB	10	3%
DIB/SDI	2	1%
VA	6	2%
Pension	1	0%
Family	2	1%
Other	36	11%
None	194	58%
Unknown	11	3%



III. December 8-9, 1983 (N=285)

<u>Age</u>	<u>Number</u>	<u>Percent</u>	<u>Marital Status</u>	<u>Number</u>	<u>Percent</u>
18-20	10	4%	Single	190	66%
21-24	29	10%	Married	19	7%
25-29	41	14%	Widowed	10	4%
30-34	57	20%	Divorced/Separated	59	21%
35-39	41	14%	Unknown	7	2%
40-44	29	10%			
45-49	24	8%	<u>Education</u>		
50-54	15	5%	None	5	2%
55 +	2	1%	Elementary	60	21%
Unknown	12	4%	High School	156	55%
Under 18	4	1%	College Degree	43	15%
			Trade School	9	3%
<u>Sex</u>			Current College	6	2%
Male	255	89%	Unknown	6	2%
Female	30	11%			
			<u>Physical Disability</u>		
<u>Ethnicity</u>			None	195	68%
White	142	50%	Temporary	34	12%
Black	90	32%	Permanent	48	17%
Hispanic	24	8%	Unknown	8	3%
Asian	5	2%			
American Indian	14	5%	<u>Mental Disability</u>		
Other	5	2%	Yes	33	12%
Unknown	5	2%	No	225	79%
			Unknown	27	9%
<u>Residence</u>					
0-3 months	82	29%	<u>Drug Abuse</u>		
4-6 months	32	11%	None	229	80%
7-11 months	14	5%	Occasional	19	7%
1-2 years	28	10%	Moderate	18	6%
2+ years	123	43%	Addicted	8	3%
Unknown	3	1%	Unknown	11	4%



<u>Alcohol Abuse</u>	<u>Number</u>	<u>Percent</u>	<u>Actual Support</u>	<u>Number</u>	<u>Percent</u>
None	172	60%	GA	46	16%
Occasional	52	18%	SSI	27	9%
Moderate	26	9%			
Severe	29	10%	<u>Veteran Status</u>		
Unknown	6	2%	Yes	82	29%
			No	195	68%
<u>Marketable Skills</u>			Unknown	8	3%
Yes	184	65%			
No	91	32%			
Unknown	10	4%			
<u>Employment History</u>					
None	22	8%			
Part Time	24	8%			
Short Term	34	12%			
1 + years	197	69%			
Unknown	6	2%			
<u>Means of Support</u>					
Job	25	9%			
GA	33	12%			
SSI	25	9%			
SSA	8	3%			
UIB	9	3%			
DIB/SDI	3	1%			
VA	8	3%			
Pension	3	1%			
Family	6	2%			
Other	20	7%			
None	132	46%			
Unknown	14	5%			



V. June 1-6, 1984 (N=243)

<u>Age</u>	<u>Number</u>	<u>Percent</u>	<u>Marital Status</u>	<u>Number</u>	<u>Percent</u>
18-20	3	1.2%	Single	180	74.1%
21-24	19	7.8%	Married	9	3.7%
25-29	44	18.1%	Widowed	10	4.1%
30-34	44	18.1%	Divorced/ Separated	40	16.5%
35-39	30	12.3%	Unknown	4	1.6%
40-44	23	9.5%			
45-49	9	3.7%			
50-54	13	5.3%	<u>Education</u>		
55 +	46	18.9%	None	4	1.6%
Unknown	12	4.9%	Elementary	40	16.5%
			High School	136	56.0%
<u>Sex</u>			College Degree	41	16.9%
Male	233	95.9%	Trade School	17	7.0%
Female	10	4.1%	Current College	2	1.0%
			Unknown		
<u>Ethnicity</u>			<u>Physical Disability</u>		
White	127	52.3%	None	167	68.7%
Black	63	25.9%	Temporary	26	10.7%
Hispanic	35	14.4%	Permanent	44	18.1%
Asian	3	1.2%	Unknown	6	2.5%
American Indian	6	2.5%			
Other	6	2.5%	<u>Mental Disability</u>		
Unknown	3	1.2%	Yes	21	8.6%
			No	202	83.1%
<u>Residence</u>			Unknown	20	8.2%
0-3 months	81	33.3%			
4-6 months	14	5.8%	<u>Drug Abuse</u>		
7-11 months	19	7.8%	None	193	79.4%
1-2 years	27	11.1%	Occasional	22	9.0%
2 + years	94	38.7%	Moderate	2	1.0%
Unknown	8	3.3%	Addicted	7	2.9%
			Unknown	19	7.8%





<u>Alcohol Abuse</u>	<u>Number</u>	<u>Percent</u>	<u>Actual Support</u>	<u>Number</u>	<u>Percent</u>
None	118	48.6%	GA	28	
Occasional	61	25.1%	SSI	13	
Moderate	26	10.7%			
Severe	30	12.3%	<u>Veteran Status</u>		
Unknown	8	3.3%	Yes	114	46.9%
			No	122	50.2%
<u>Marketable Skills</u>			Unknown	7	2.9%
Yes	169	69.5%			
No	70	28.8%			
Unknown	4	1.6%			
<u>Employment History</u>					
None	6	2.5%			
Part Time	9	3.7%			
Short Term	34	14.0%			
1 + years	186	76.5%			
Unknown	8	3.3%			
<u>Means of Support</u>					
Job	18	7.4%			
GA	17	7.0%			
SSI	13	5.3%			
SSA	10	4.1%			
UIB	4	1.6%			
DIB/SDI	2	1.0%			
VA	5	2.1%			
Pension	0	0			
Family	1	0.4%			
Other	5	2.1%			
None	160	65.8%			
Unknown	8	3.3%			



IV. March 6, 1984 (N=204)

<u>Age</u>	<u>Number</u>	<u>Percent</u>	<u>Marital Status</u>	<u>Number</u>	<u>Percent</u>
18-20	8	3.9%	Single	132	64.7%
21-24	14	6.9%	Married	19	9.3%
25-29	32	15.7%	Widowed	10	4.9%
30-34	30	14.7%	Divorced/Separated	39	19.1%
35-39	37	18.1%	Unknown	4	2.0%
40-44	10	4.9%			
45-49	16	7.8%	<u>Education</u>		
50-54	12	5.9%	None	4	2.0%
55 +	24	11.8%	Elementary	34	16.7%
Unknown	21	10.3%	High School	109	53.4%
			College Degree	31	15.2%
<u>Sex</u>			Trade School	15	7.3%
Male	181	88.7%	Current College	8	3.9%
Female	23	11.3%	Unknown	3	1.5%
<u>Ethnicity</u>			<u>Physical Disability</u>		
White	112	54.9%	None	128	62.7%
Black	56	27.5%	Temporary	23	11.3%
Hispanic	6	2.9%	Permanent	42	20.6%
Asian	5	2.5%	Unknown	11	5.4%
American Indian	9	4.4%			
Other	8	3.9%	<u>Mental Disability</u>		
Unknown	8	3.9%	Yes	21	10.3%
			No	159	77.9%
<u>Residence</u>			Unknown	24	11.8%
0-3 months	54	26.5%			
4-6 months	17	8.3%	<u>Drug Abuse</u>		
7-11 months	12	5.9%	None	150	73.5%
1-2 years	15	7.4%	Occasional	17	8.3%
2 + years	96	47.0%	Moderate	12	5.9%
Unknown	10	4.9%	Addicted	11	5.4%
			Unknown	14	6.9%



<u>Alcohol Abuse</u>	<u>Number</u>	<u>Percent</u>
None	95	46.6%
Occasional	44	21.6%
Moderate	29	14.2%
Severe	26	12.7%
Unknown	10	4.9%

<u>Marketable Skills</u>		
Yes	129	63.2%
No	68	33.3%
Unknown	7	3.5%

<u>Employment History</u>		
None	12	5.9%
Part Time	20	9.8%
Short Term	28	13.7%
1 + years	136	66.7%
Unknown	8	3.9%

<u>Means of Support</u>		
Job	7	4.4%
GA	28	12.2%
SSI	17	8.3%
SSA	7	3.4%
UIB	6	2.9%
DIB/SDI	0	0
VA	4	2.0%
Pension	4	2.0%
Family	2	1.0%
Other	11	5.4%
None	106	52.0%
Unknown	13	6.4%

<u>Actual Support</u>	<u>Number</u>	<u>Percent</u>
GA	28	13.7%
SSI	21	10.3%

<u>Veteran Status</u>		
Yes	61	29.9%
No	143	70.1%



Appendix 1.2

Excerpts from

H O M E L E S S   Y O U T H   I N   S A N   F R A N C I S C O

SUBMITTED BY:

THE MAYOR'S CRIMINAL JUSTICE COUNCIL

Through the efforts of:

The Homeless Youth Subcommittee of the  
AB/90 Youth Services Task Force

March, 1984





## INTRODUCTION

In December, 1982 San Francisco began to implement an expanded emergency shelter program for the increasing number of homeless adults in the City. At the same time a growing concern over the plight of homeless youth began to emerge.

On April 11, 1983 the Board of Supervisors passed a resolution urging the Mayor to appoint a Task Force whose function would be to develop a comprehensive strategy and specific proposals for the delivery of services to homeless youth. Subsequently, Mayor Dianne Feinstein designated a special committee within the Youth Services/AB 90 Task Force of the Mayor's Criminal Justice Council to accomplish this goal.

For purposes of their study, the Committee defined homeless youth as follows:

Any persons under the age of eighteen years who is destitute, or who is not provided with the necessities of life, or who is not provided with a home or suitable place of abode. Such youth include but are not limited to youth who are:

- Both males and females involved in prostitution or other street hustling in order to survive;
- Runaways who are at risk of prostitution and drug involvement, including both San Francisco and out-of-county youth;
- Older teenagers who have failed in placement or who have been inappropriately placed in the foster care system and have fled from it;
- Unaccompanied minors originating from outside the United States;
- Minors who are "pushed out" of their homes and have no permanent alternative.

Over the next several months the Committee reviewed numerous reports and studies which explored the problems of homeless and street youth. Additionally, the Committee also heard testimony from a wide variety of people (which included medical practitioners, researchers, mental health specialists, probation officers, social workers, community agency and group home providers, police officers, foster parents and homeless youth themselves) regarding their perspective on the nature and scope of the homeless youth problem. Finally, a citywide survey of community-based agencies was also conducted to gain a broader perspective on the scope of this problem.

In combination with a review of the research, the testimony received from presenters served as the foundation from which this report emanates.



## SUMMARY OF FINDINGS

- There are an estimated 1,000 homeless youth on San Francisco's streets every night; these homeless youth come from every racial and ethnic group in the City.
- Many of the homeless youth are "throwaways" - that is, their families forced them out, often through physical and sexual abuse. This seems particularly true of the female runaways. Many boys appear to have been forced out due to their self-identification as gay.
- The number of undocumented minors from Central and South America is increasing at a rapid rate.
- Foster care placement failures appear to form a significant percentage of the out-of-county and out-of-state homeless youth.
- Drug abuse is common among the homeless population. This frequently leads to severe medical and psychiatric problems.
- There appears to be a high incidence of prostitution among this population or, at the very least, a trading of sexual favors in exchange for necessities. This often only perpetuates physical and sexual abuse of these children, abuse that many of them had tried to flee by running away.
- Lack of adequate shelter, lack of nutrition, lack of guidance, drug abuse and the "street" lifestyle all contribute to homeless youths' serious physical and mental problems.
- Many homeless youth are afraid of the social service delivery system and therefore only come to medical care when in dire need. This leads to under-treatment and to a high incidence of severe physical and emotional diseases.
- The service delivery system for the out-of-county and out-of-state homeless population is especially inadequate and ineffective since there are gaps in service presently being provided by D.S.S. and the Juvenile Probation Department.
- Federal administration rule changes limiting foster care payments to youth under 18 have made it very difficult to find placements for teens approaching that age. This is a particularly severe problem for those adolescents who are mentally ill and who need supervised care.
- Although it is desirable to return the children to their home communities, it is not always feasible or in the best interest of every child to do so.



## RECOMMENDATIONS REGARDING SERVICES NEEDED

### Early Identification and Intervention

- Multi-service/drop-in centers - located in target communities, offering health, counselling, outreach, street work, education, legal and employment services.

### Short-Term Crisis Programs

- Beds at foster-group homes, hotels, churches--offering 72-hour maximum stay, having permanent locations, and capacity between 6 and 12 youth each.

### Transition Programs

- Shelter provided for a six week to six month basis to allow for planning and establishment of a long term, living environment. Employment and/or educational services would be attached.

### Long-Term Programs

- Specialized foster/group homes--including mental health and substance abuse treatment centers, staff appropriate to and trained in working with homeless young people, especially non-English speaking and sexual minority youth.



Appendix 2.1

Medical, Surgical, and Psychiatric Problems  
of Homeless Patients Admitted to  
San Francisco General Hospital  
January-March, 1983

John T. Kelly, M.D., Ph.D.





The homeless suffer a broad range of serious health problems. To identify their medical, surgical, and psychiatric problems that were sufficiently serious to require hospitalization, the medical records of homeless persons admitted to San Francisco General Hospital during the first quarter of 1983 were reviewed. San Francisco General Hospital, the "County Hospital", is the facility in San Francisco designated for providing inpatient treatment to all residents of San Francisco who are indigent and without medical insurance.

The method used to identify the homeless persons admitted to San Francisco General Hospital was to review the financial screening records for all 4436 admissions to San Francisco General Hospital from January 1, 1983 to March 31, 1983. Patients whose address was identified as "streets", "transient", or "no local address" were considered homeless. This method underestimates the actual number of homeless inpatients because it excludes homeless patients who gave addresses of places such as shelters, former residences, or mailing addresses. Through this approach, 318 different patients admitted during this quarter were identified as homeless. The 318 patients accounted for 340 (7.7%) of the admissions to San Francisco General Hospital during this period.

Of the 318 homeless patients admitted to San Francisco General Hospital during the first quarter of 1983, the medical records of 257 (80.8%) were available for review during the last two weeks of May, 1984. These 257 homeless patients constituted the sample studied. The data collected on each patient included name, sex, date of birth, medical record



number, date of first admission during the quarter, date of discharge, discharge diagnoses, dates and discharge diagnoses of prior hospitalizations at San Francisco General Hospital, and dates and discharge diagnoses of subsequent hospitalizations at San Francisco General Hospital (during the period after their first admission during the first quarter of 1983 until the review was conducted during the last two weeks of May, 1984).

The discharge diagnoses of the 257 homeless patients in the sample covered a broad spectrum. The primary reason for hospitalization of 58.4% of the sample was medical and/or surgical; the primary reason for hospitalization of the other 41.6% of the sample was psychiatric.

77.8% of the patients in the sample were male and 22.2% were female. Such male predominance is similar to the predominance of males in the homeless population in San Francisco. Homeless men accounted for 85.3% of the admissions of homeless patients to the medical and/or surgical services, whereas homeless women accounted for only 14.7% of the homeless patients on these services. Homeless men accounted for 67.3% of the admissions of homeless patients to the psychiatric service, whereas homeless women accounted for 32.7% of the homeless patients on the psychiatric service. Thus, homeless men were disproportionately represented on the medical and surgical services, and homeless women were disproportionately represented on the psychiatric service.

The homeless patients in the sample covered a broad range of ages, from less than 20 to over 80. The median age range of the homeless men



on the medical and surgical services was 35 to 39; the median age range of homeless men on the psychiatric service was 25 to 29. The median age range of the homeless women on the medical and surgical services was likewise 35 to 39, whereas the median age range of the homeless women on the psychiatric service was 30 to 34. Thus the homeless patients on the medical and surgical services tended to be older than the homeless patients on the psychiatric service.

Of the 150 homeless patients on the medical and surgical services, the most frequent diagnosis was cellulitis, which accounted for 24.7% of the patients. Respiratory problems, such as pneumonia, chronic obstructive pulmonary disease, and tuberculosis, and alcohol-related problems accounted for almost another quarter of the patients. Stab wounds and major lacerations, fractures, and non-surgical gastrointestinal problems such as pancreatitis, hepatitis, and gastrointestinal bleeding accounted for almost another quarter of the patients. The remainder of the patients had a broad range of other problems, including congestive heart failure, stroke, hypothermia, head and blunt trauma, bites, burns, dehydration, gangrene, hepatic encephalopathy, hypothyroidism, and cardiac arrest.

Of the 107 homeless patients on the psychiatric service, the most frequent diagnosis was schizophrenia, which accounted for over one-third of the patients. Paranoid schizophrenia was the most frequent type of schizophrenia encountered. Another frequent diagnostic category was major affective disorder, which accounted for 27.1% of the patients. Bipolar manic disorder was the most common type of affective disorder, and depression was the second most common type of affective disorder. Other



frequent diagnoses were atypical psychosis, substance abuse, adjustment disorder, paranoid disorder, and schizoaffective disorder.

The homeless patients in the sample accounted for a total of 2302 inpatient days. The 150 homeless patients on the medical and surgical services accounted for 1034 inpatient days, an average of 6.9 days per person. The 107 homeless patients on the psychiatric service accounted for 1268 inpatient days, an average of 11.9 days per person. Lengths of stay varied widely, from 0 to 80 days on the medical and surgical services, and from 0 to 58 days on the psychiatric service. The median length of stay of homeless patients on the medical and surgical services was 5 days, whereas the median length of stay on the psychiatric service was 8 days.

The hospitalizations of the homeless patients in the sample represent a tremendous allocation of resources. If it is estimated that the average cost per inpatient day at San Francisco General Hospital is \$650, expenditures for the 257 homeless patients totaled \$1,496,300. during the first quarter of 1983. If these figures are adjusted to account for the 61 homeless patients admitted to San Francisco General Hospital during the quarter studied whose medical records were not available for review, total expenditures for the 318 homeless patients admitted to San Francisco General Hospital during the first quarter of 1983 exceeded \$1,850,000. This represents an annualized expenditure of over \$7,400,000. for inpatient medical, surgical, and psychiatric services at San Francisco General Hospital for homeless persons. Despite its enormous size, this estimate





likely under-represents the actual scale of expenditures for homeless patients at San Francisco General Hospital, because the sample underestimated the actual number of homeless inpatients at San Francisco General Hospital

The homeless patients in the sample had a remarkably high rate of hospitalization at San Francisco General Hospital prior to and subsequent to their first admission during the period studied. 50% of the homeless patients admitted to the medical or surgical service at San Francisco General Hospital during the first quarter of 1983 had been hospitalized previously at San Francisco General Hospital. 51.4% of the homeless patients admitted to the psychiatric service at San Francisco General Hospital during the first quarter of 1983 had been hospitalized previously at San Francisco General Hospital. Many of these patients had been hospitalized multiple times at San Francisco General Hospital. Of the 130 homeless patients in the sample who have been admitted previously to San Francisco General Hospital, the frequency of prior hospitalization was as follows:

<u>Prior Admissions</u>	<u>Sample (N=130)</u>
1	36.2%
2	21.5%
3	13.8%
4	13.1%
5	6.2%
6	5.4%
7	2.3%
8	1.5%



The frequency of subsequent admissions to San Francisco General Hospital for the homeless patients in the sample was likewise high. 38.7% of the homeless patients admitted to the medical and/or surgical service and 37.4% of the homeless patients admitted to the psychiatric service at San Francisco General Hospital were hospitalized again during the period after their first hospitalization in the first quarter of 1983 until the last 2 weeks of May, 1984, when the medical records were reviewed. Of the 98 homeless patients in the sample who were admitted subsequently to San Francisco General Hospital, the frequency of subsequent hospitalization was as follows:

<u>Subsequent Admissions</u>	<u>Sample (N=98)</u>
1	48.0%
2	19.4%
3	12.2%
4	5.1%
5	0%
6	2.0%
7	1.0%
8	2.0%

The diagnoses of the patients hospitalized at San Francisco General Hospital prior and subsequent to the period studied were similar to the diagnoses of the patients hospitalized during the period studied.

In summary, this review of homeless patients admitted to San Francisco General Hospital indicates that:

- o the homeless account for a substantial portion of the patients



admitted to the hospital;

- o the homeless patients had a broad range of serious acute and chronic medical, surgical, and psychiatric problems;

- o a major subset of the homeless patients were hospitalized multiple times;

- o some of the admissions, such as those for cellulitis, pneumonia, or chronic schizophrenia might have been preventable had the patients received appropriate treatment in a timely manner.

The gravity of these problems suggest the value of further investigation of the medical, surgical, and psychiatric needs of the homeless, and re-assessment of the ways in which services are provided to the homeless.



Age (medical/surgical)

N=150

<u>Age</u>	<u>Male (N=128)</u>	<u>Female (N=22)</u>
<20	1.6%	
20-24	9.4%	
25-29	4.7%	22.7%
30-34	21.9%	22.7%
35-39	17.2%	27.3%
40-44	7.8%	
45-49	10.9%	
50-54	5.5%	4.5%
55-59	10.2%	9.1%
60-64	5.5%	4.5%
65-69	0.8%	4.5%
70-74	1.6%	
75-79	1.6%	
80-		4.5%
Unknown	1.6%	





Age (psychiatric)

N=107

<u>Age</u>	<u>Male (N=72)</u>	<u>Female (N=35)</u>
< 20	2.8%	2.9%
20-24	19.4%	11.4%
25-29	27.8%	17.1%
30-34	13.9%	28.6%
35-39	19.4%	20.0%
40-44	6.9%	11.4%
45-49	4.2%	
50-54		5.7%
55-59	2.8%	
60-64	1.4%	
65-		2.9%
Unknown	1.4%	



Diagnosis (medical/surgical) N=150

Cellulitis	24.7%
Respiratory	12.0%
Alcohol withdrawal/seizures/ intoxication	11.3%
Stab wound/laceration	8.6%
Fracture	8.0%
Gastrointestinal (medical)	6.0%
Non-alcoholic substance withdrawal/ intoxication	5.3%
Cardiovascular (medical)	2.7%
Neurological	2.7%
Orthopedic (non-fracture)	2.7%
Hypothermia	2.0%
Blunt trauma	2.0%
Gynecological	2.0%
Gastrointestinal (surgical)	2.0%
Head trauma	1.3%
Gunshot	0.7%
Burn	0.7%
Bite	0.7%
Vascular (surgical)	0.7%
Cardiac arrest	0.7%
Dehydration	0.7%
Gangrene	0.7%
Hematological	0.7%
Encephalopathy	0.7%
Endocrinological	0.7%



## Diagnosis (psychiatric)

N=107

Schizophrenia	(N=37)	34.6%
Paranoid	59.5%	
Undifferentiated	35.1%	
Disorganized	5.4%	
Major affective disorder	(N=29)	27.1%
Bipolar manic	44.8%	
Bipolar, unspecified	10.3%	
Depression	41.4%	
Other	3.4%	
Atypical Psychosis		8.4%
Substance Abuse		8.4%
Alcohol	44.4%	
Mixed/non-alcohol	55.6%	
Adjustment disorder		5.6%
Paranoid disorder		3.7%
Schizoaffective disorder		2.8%
Borderline personality		1.9%
Mental retardation		1.9%
Acute confusional state		0.9%
Dysthymic disorder		0.9%
Intermediate explosive disorder		0.9%
Dementia		0.9%
Mixed organic mental disorder		0.9%
Other		0.9%



## Length of Stay (medical/surgical) - Days

N=150

0	0.7%
1	14.0%
2	14.0%
3	11.3%
4	5.3%
5	10.7%
6	11.3%
7	8.0%
8	5.3%
9	2.7%
10	2.7%
11	1.3%
13	1.3%
14	0.7%
15	0.7%
16	0.7%
17	0.7%
19	2.0%
20	2.7%
22	0.7%
24	0.7%
29	0.7%
35	0.7%
45	0.7%
80	0.7%

median stay: 5 days





## Length of Stay (psychiatric) - Days

N=107

0	1.9%
1	11.2%
2	9.3%
3	8.4%
4	1.9%
5	1.9%
6	3.7%
7	8.4%
8	5.6%
9	2.8%
10	4.7%
11	2.8%
12	2.8%
13	4.7%
14	1.9%
15	5.6%
16	0.9%
17	1.9%
20	0.9%
21	0.9%
22	0.9%
23	0.9%
24	0.9%
26	0.9%
28	0.9%
30	2.8%
33	0.9%
36	1.9%
37	1.9%
38	1.9%
39	0.9%
52	0.9%
55	0.9%
58	0.9%

median stay: 8 days



Admissions (medical/surgical)

N=150

	<u>Previous</u>	<u>Subsequent</u>
0	50.0%	61.3%
1	18.7%	17.3%
2	8.0%	12.7%
3	8.0%	4.7%
4	6.0%	2.0%
5	3.3%	0.0%
6	4.0%	0.7%
7	0.7%	0.7%
8	1.3%	0.7%



## Admissions (psychiatric)

N=107

	<u>Previous</u>	<u>Subsequent</u>
0	48.6%	62.6%
1	17.8%	19.6%
2	15.0%	9.3%
3	5.6%	4.7%
4	7.5%	1.9%
5	2.8%	
6	0.9%	0.9%
7	1.9%	
8		0.9%



## Appendix 2.2

### Utilization of Medical and Psychiatric Services by Homeless Persons in San Francisco

John T. Kelly, M.D., Ph.D., Stephen Goldfinger, M.D., Robert Surber,  
Ellie Dwyer

The homeless are known to have a wide range of medical, psychiatric, and substance abuse problems, and to be heavy users of medical and psychiatric services. However, the extent to which the homeless in San Francisco use medical and psychiatric services has not been established. To obtain data on the utilization of medical and psychiatric services by the homeless in San Francisco, representatives of the San Francisco Department of Public Health interviewed 170 homeless persons in San Francisco in March, 1984.

#### Procedure

A team of two social workers and two nursing students interviewed homeless persons at three Emergency Shelters (Episcopal Sanctuary, Hospitality House, and St. Vincent de Paul Shelter) and at one food line for the indigent (St. Anthony's Dining Room). The interviews at the shelters were conducted on three consecutive Thursday evenings, and the interviews at the food line was conducted on one Thursday morning. The respondents were approached directly, at random, in the socialization areas of the shelters and in the food line.

The interviewers obtained verbal consent from each respondent and the right to refuse was honored. Each participant was informed that the





San Francisco Department of Public Health was conducting a survey of the medical and mental health needs of the homeless and that the information gathered will be used for program planning. Anonymity was maintained in the sense that no identifying information was requested other than age and ethnicity. All of the interviews were conducted in English with the exception of four interviews in Spanish.

The interviewers used a standardized questionnaire that requested information regarding each respondent's age, sex, race, use of medical and psychiatric services during the last year, use of medications, history of psychiatric hospitalization, and history of substance abuse (see questionnaire). The questionnaires took approximately seven minutes to complete, including introductions.

### Sample

The total sample included 70 respondents. One hundred forty-seven were male and twenty-three were female. The ages of the participants ranged from 15 to 70. Approximately twenty percent of the men approached refused to participate in the survey while almost 50% of the women approached refused. Generally, the men were friendly and cooperative while the women were more suspicious, fearful and hostile. As an illustration of the hostility evident among many of the women, one woman is quoted as shouting "I have no business with you, I have no business with you." Three women and only one man insisted on completing the questionnaire with the assistance of the interviewer.

All persons who agreed to answer the questions did so successfully.



Thus, the mental status at the time of the interview was sufficiently stable to participate in the survey. Those persons who appeared to be incoherent were not approached as the responses required a self-report of current and past medical and psychiatric needs. This relatively high refusal rate and the fact that some possible respondents were not approached because of their apparent inability to participate, both indicate that the sample likely underestimates the incidence of psychiatric illness and the incidence of substance abuse among the homeless.

#### Data

Sample:	N=170
Sex: Male (N=147)	86.5%
Female (N=23)	13.5%
Age: <21	4.1%
21-35	45.3%
36-50	28.8%
51-65	17.6%
>65	4.1%
Medical Services:	
Received medical services during last year (N=129)	75.9%
a. Received medical services during previous months (N=104)	61.2%
b. Received medical services during last year, but not during previous 3 months (N=25)	14.7%



Type of medical services used during last year (N=129)

Outpatient Department	83.3%
Emergency Department	76.7%
Inpatient	30.2%

Psychiatric Services:

Received psychiatric services during last year (N=38)	22.4%
--	-------

Type of psychiatric services used during  
last year (N=38)

Outpatient	65.8%
Acute	28.9%
Residential	13.2%
Day treatment	10.5%
Longterm	5.3%

Psychiatric History:

History of Psychiatric hospitalization (N=59)	34.7%
<6 months	16.9%
6-12 months	8.5%
1-3 years	20.3%
4-10 years	23.7%
>10 years	30.5%



#### Substance Abuse:

History of alcohol or drug abuse (N=98)	57.6%
Status of substance abuse (N=98)	
Chronic problem	65.3%
Past problem	30.6%
Recent problem	4.1%

#### Discussion

The sample represents a cross-section of homeless men and women of a broad range of ages at several different shelters and a food line in San Francisco. Consequently, the data are likely to be representative of the entire homeless population in San Francisco.

The most impressive feature of the data is the extraordinarily high rate of utilization of medical services. Over seventy-five percent of the sample used medical services during the last year, and of these more than eighty percent did so during the previous three months. More than thirty percent of those who used medical services during the last year were inpatients. Such data on the utilization of inpatient and outpatient services suggest a remarkably high incidence of medical illness.

The appropriateness with which medical services were used by the sample was not evaluated by the survey. Nevertheless, it is unlikely that homeless patients, who are characteristically indigent and without medical insurance, would be hospitalized unnecessarily. That more than three-quarters of those who received medical services utilized an emergency





department may reveal a large incidence of true emergencies, but also raises the possibility that some utilized emergency departments because other more appropriate services were not available. The costs of providing medical services to the homeless were not evaluated by the survey. However, the high rate of utilization of inpatient medical services indicate that considerable financial resources were expended in providing services to the sample. An important question raised by the survey is whether medical services could have been provided in a more cost-effective manner. For example, could preventive measures or earlier interventions have prevented some of the hospitalizations?

Another impressive aspect of the data is the high incidence of psychiatric hospitalization. More than one-third of the sample admitted to a history of previous psychiatric hospitalization, and almost half of those had their most recent psychiatric hospitalization during the past three years. Such data suggest a high incidence of previous mental illness among the sample. Nevertheless, less than one-quarter of the sample received any psychiatric services during the last year. It is likely that many of the mentally ill among the sample went without or received inadequate mental health services.

The survey revealed a remarkably high incidence of substance abuse among the sample, with almost sixty percent reporting that they have experienced problems with alcohol and/or drug abuse, and almost two thirds of these indicating that their substance abuse problems were chronic.



The above data indicate that there is an extraordinarily high rate of utilization of medical and psychiatric services by the homeless, and indicate that there is a high incidence of medical illness, psychiatric illness, and substance abuse among the homeless. Efforts to provide for the needs of the homeless in San Francisco must take into account the incidence of such serious health problems among this population.



Age: \_\_\_\_\_ Sex: ☐ Male ☐ Female

Race: W ☐ B ☐ A ☐  
S ☐ O ☐

1.a. Have you received any medical services in the last 3 months?

☐ Yes ☐ No

b. If yes, where?

☐ Emergency room  
☐ Outpatient clinic  
☐ Inpatient

2.a. Have you received any medical services in the last 12 months?

☐ Yes ☐ No

b. If yes, where?

☐ Emergency room  
☐ Outpatient clinic  
☐ Inpatient

3.a. Are you taking (or are you supposed to be taking) any medications?

☐ Yes ☐ No

b. If yes, what medications?

Name: \_\_\_\_\_

4.a. Have you received any mental health or psychiatric services in the last 12 months?

☐ Yes ☐ No

b. If yes, where?

☐ Outpatient  
☐ Residential  
☐ Other day treatment  
☐ Acute hospital  
☐ Long-term hospital (State, I-facility)

5.a. Have you ever been a patient in a psychiatric hospital?

☐ Yes ☐ No

b. If yes, when was the most recent time?

☐ Last 6 months ☐ Last 10 years ago  
☐ Last year ☐ More than 10 years ago  
☐ Last 3 years

6.a. Have alcohol or drugs been a problem for you during the last 6 months?

☐ Yes ☐ No

b. Have alcohol or drugs ever been a problem for you?

☐ Yes ☐ No

c. Have you ever received treatment for alcohol or drug abuse?

☐ Yes ☐ No



Medical Problems of Homeless Patients  
at Central Emergency, 1983

John T. Kelly, M.D., Ph.D.

Central Emergency, an outpatient emergency facility operated by the San Francisco Department of Public Health in the downtown area of San Francisco where many of the homeless reside, treats a wide range of minor medical and surgical problems among the homeless. It is estimated that around 300 to 400 of the approximately two thousand patients treated monthly at Central Emergency are homeless.

Central Emergency is open around the clock, every day of the year. Physicians and nurses are always on duty. Services are available to everyone, regardless of ability to pay. Indigent patients are not billed for services. Medications are provided to indigent patients without charge. The facilities consist of two examining rooms, two open observation areas, a small laboratory and a small pharmacy. Radiographic facilities are not available.

To identify the types of medical problems for which the homeless receive treatment at Central Emergency, the medical records of all patients treated during the first six months of 1983 were surveyed. Patients whose addresses were listed as "no address", "no local", or "streets" were identified as homeless and comprised the group studied. The charts of one hundred consecutive homeless patients were reviewed.





The primary diagnoses of the homeless patients (N=100) were:

Infestation	24%
Laceration	17%
Upper respiratory infection/bronchitis	11%
Cellulitis	8%
Alcohol-related (acute/chronic)	5%
Foot problem	4%
Dermatitis (non-infestation)	3%
Bite	3%
Psychosis	3%
Gastroenteritis	3%
Urinary tract infection/vaginitis	3%
Arthritis	3%
Head trauma	2%
Otitis	2%
Neuropathy	2%
Burn	2%
Headache	1%
Contusion	1%
Osteomyelitis	1%
Sexual assault	1%
Gunshot wound	1%

Infestation was the most common diagnosis among the homeless treated at Central Emergency. Other skin problems, including cellulitis, foot problems, and dermatitis were also prominent. Laceration was the second most frequent



diagnosis. Also frequent were infections such as upper respiratory infection, bronchitis, gastroenteritis, and urinary tract infection.

The capability of providing examination, treatment, and medications without charge to homeless and other indigent patients contributed greatly to the accessibility of services. Especially remarkable is the fact that most of the problems for which the homeless presented to Central Emergency could be readily diagnosed and treated at a facility with such limited resources. Few of the patients required referral to San Francisco General Hospital for further evaluation or treatment. Thus, a clinic such as Central Emergency, which is readily accessible to the geographic areas where the homeless reside, and which has extended hours and drop-in capability, can be an important means for delivering medical care to the homeless.



## Appendix 2.4

### Medical Clinic at Grace Cathedral Emergency Shelter, 1983

Daniel Wlodarczyk, M.D., John T. Kelly, M.D., Ph.D.

The San Francisco Department of Public Health operated a medical clinic at Grace Cathedral Emergency Shelter in San Francisco in March, 1983. The medical clinic, staffed by a physician, a public health nurse, and a volunteer, was operated for approximately two hours each evening, from 8:30 to 10:30 P.M. All shelter residents who requested medical care were evaluated and, as appropriate, advised, treated, or referred. An average of 155 homeless persons (range: 80-211) slept at the shelter each night.

Review of the medical records of eight sessions of the clinic, from March 16 to March 25, revealed the following:

Average number of patient visits per clinic	11
Average number of visits per patient	1.2

#### Males (N=70)

Age:	20-29	25.7%
	30-39	42.9%
	40-49	15.7%
	50-59	12.9%
	60 -	2.9%



Females (N=18)

Age: 20-29	22%
30-39	33%
40-49	28%
50-59	17%

Primary Diagnoses (N=93).

Upper respiratory infection	25.8%
Hypertension	11.8%
Bronchitis/pneumonia	9.7%
Foot problems	9.7%
Health question	8.6%
Musculoskeletal	8.6%
Dental	4.3%
Skin problem (non-infestation)	3.2%
Infestation	3.2%
Alcohol-related	3.2%
Cardiovascular (non-hypertension)	2.2%
Pregnancy-related	2.2%
Psychiatric	2.2%
Neurological	2.2%
Trauma	1.1%
A.I.D.S.	1.1%
Drug overdose	1.1%

- Almost 6% of the patients (N=5) required emergency transport by ambulance to San Francisco General Hospital for further





evaluation and treatment. The primary diagnoses of these patients were:

1. Accelerating angina
2. Drug overdose
3. Pancreatitis
4. Lung abscess
5. Pneumonia

The above data indicate that the homeless shelter residents at Grace Cathedral Emergency Shelter had a broad range of medical problems. Often, problems such as bronchitis, hypertension, dental problems, and psychiatric disorders, had been long-standing and had remained unevaluated and untreated until the patients were seen at the shelter clinic. Many of these problems could be treated with relatively simple therapeutic interventions, such as antibiotics. Other problems could be treated after appropriate referral. Many of the conditions, such as foot problems and musculoskeletal disorders, although not serious, had significant adverse impact on the patients' health. Some of the patients had serious medical problems that might have remained untreated, or for which treatment would have been further delayed, had they not been evaluated at the clinic. It was the consensus of the staff and residents of the shelter, as well as the staff of the clinic, that the clinic was a valuable resource for the homeless who slept at Grace Cathedral Emergency Shelter and is a useful model for clinics in other shelters.



Appendix 3.1

" SAN FRANCISCO "

Reproduced from:

Homelessness in America's Cities,

Ten Case Studies

United States Conference of Mayor's,

June, 1984



## SAN FRANCISCO

Mayor: Dianne Feinstein  
Population: 678,974  
Poverty Rate: 13.7%  
Unemployment Rate: March, 1980 -- 5.0%  
March, 1983 -- 9.2%  
March, 1984 -- 7.6%

### Problems

Although it is not known how many people are actually homeless in San Francisco, it has become evident to those working close to the problem that the number has risen dramatically in recent years. Between December 1982, when the City's Shelter for the Homeless Program began, and March, 1983 alone, the number of people housed in City-funded shelters doubled from an average of 577 to over 1,150 persons each night. New shelters were full to capacity as soon as they opened. The City's program was initiated shortly after representatives of private organizations serving the homeless brought the severity of the problem and the fact that their agencies were being overwhelmed by the demand for assistance to the attention of Mayor Dianne Feinstein. The Salvation Army and other traditional shelter agencies reported seeing requests for emergency assistance double between 1981 and 1982. Because of lack of resources, many homeless persons were not being served.

City officials estimate that, based on the number of homeless people receiving General Assistance--a City-funded relief program -- the demand for emergency shelter continued to increase significantly in 1983. Last December, the General Assistance caseload was 9,797, a 43 percent increase over December, 1982. This increase is largely attributed to an intensive effort initiated last year by the City to place homeless persons found to be eligible on General Assistance.

People seeking emergency shelter in San Francisco today include larger numbers of families and unemployed young people who are in the streets for the first time in their lives. Many of them have recently moved there from other cities in search of a job. Information provided by the San Francisco Department of Social Services, based on a survey of persons using shelters in March 1984, revealed the following characteristics of this population:

- Forty-one percent of homeless people at the shelters were between 18 and 35 years of age; 89 percent were men; 52 percent were White, 28 percent Black, and 11 percent Hispanic. Native Americans, while comprising less than one-half of one percent of the city's population, account for about three percent of the homeless.



- Fifty-three percent had completed their high school education; 15 percent were college graduates.
- Sixty-three percent indicated having marketable skills; 67 percent reported holding a job for over one year.
- Twenty-four percent receive public assistance; 52 percent have no means of support.
- Forty-one percent had lived in San Francisco for less than one year, 27 percent for less than four months; 30 percent of those who had recently moved to San Francisco came from other cities in California.
- Thirty-two percent have temporary or permanent physical disabilities; 12 percent admitted having mental health problems. (The San Francisco Department of Public Health estimates, however, that the number of homeless persons who are mentally ill is more than double that figure.)
- Forty-eight percent reported some form of alcohol abuse; 20 percent reported some form of drug abuse.

It is important to note that the survey did not include information on homeless families or single adults being housed in hotels.

According to city officials, the principal underlying causes of the recent dramatic increase in the problem of homelessness in San Francisco are:

- Lack of housing available to low-income people.
  - In 1975, there were 32,214 residential hotel units in San Francisco. By the end of 1979, that number had dropped to 26,491. Despite a moratorium passed by the San Francisco Board of Supervisors in 1979 prohibiting the conversion of SRO units, the number of those units has continued to decline to less than 21,000 today.
  - Between 1971 and 1983 evictions in San Francisco increased by 190 percent from 2,000 to over 5,800. There has also been a significant increase in the number of persons who have been kicked out of the homes of relatives or friends with whom they had "doubled up."
- Unemployment -- San Francisco's unemployed have been joined by many persons from other cities around the country who have migrated there in search of a job, only to find none was available to them.
- Deinstitutionalization -- It is estimated that 25 to 35 percent of those who utilize the shelter system on a regular basis are mentally ill persons who have been forced into the streets as a result of the State's deinstitutionalization





policies. In 1983 there were approximately 5,000 patients in public psychiatric hospitals in California, only 13 percent of the 37,000 who were in those institutions in 1960. During the same period of time, the state's population increased by fifty percent.

## Responses

On November 5, 1982, members of the Central City Shelter Network, a coalition of private, non-profit organizations, and other concerned groups, met with Mayor Feinstein to discuss the plight of homeless people in San Francisco and to ask for increased involvement of the City in addressing the growing problem of homelessness. The Mayor was told that private agencies were unable to meet the increased demand for shelter and as a result were forced to turn many people away. Their ability to provide this basic service without active government support and assistance had reached its limit.

After hearing about the extent of the problem, Mayor Feinstein responded quickly, mobilizing both public and private resources to meet the urgent needs of homeless people. Shortly after the meeting, she sought supplemental appropriations from the Board of Supervisors to fund shelter programs. The plight of the homeless had also attracted the attention of the Board, which in November held a lengthy public hearing, attended by over 300 people, on the problem of homelessness in the city. The Board of Supervisors subsequently joined the Mayor in her efforts to address the problem. At the same time, plans were developed to expand these efforts by enlisting the cooperation and assistance of the religious community to provide shelter space in churches and synagogues. What developed then was a strong partnership between the executive and legislative branches of the city government and the private sector to provide much needed assistance to people who are homeless.

On December 3, Mayor Feinstein established a Task Force on the Homeless "to identify the problems of the homeless and to develop appropriate shelter space and other services needed by that population." The Mayor's Task Force is comprised of 25 members, representing City agencies, the Board of Supervisors, private agencies serving homeless people and concerned individuals. Initially, the Task Force met and provided reports to Mayor Feinstein on a daily basis. Currently, it meets as a group bi-weekly and with the Mayor once a month. A principal responsibility of the Task Force has been the monitoring of the Mayor's Shelter for the Homeless Program.

The Mayor's program began on December 1, 1982, with 194 persons sheltered in four facilities. Almost daily, religious organizations and concerned citizens stepped forward to help and join the effort. In addition to funding, the City, using "emergency provisions" available from the Department of Public Health, furnished cots and blankets to the churches. Each night, volunteers at the shelters



set up the cots and provided other staff support services, such as preparing and distributing light supper and breakfast. Only three months after it was established, the Mayor's shelter program was housing over 1,200 homeless persons in 14 facilities.

In April, when the funds initially allocated by the City expired, Mayor Feinstein announced that the temporary shelter program would be significantly modified and replaced with a "more efficient, cost-effective one." Under the new plan, homeless people were moved from church shelters into several hotels for two weeks. There officials from the Department of Social Services evaluated them to determine if they were eligible to receive General Assistance--\$248 a month for singles, more for families--or other public assistance. Those persons found to be eligible could then choose to be housed in hotels, under a vendor/voucher system, or find housing on their own. According to Mayor Feinstein, the aim of the program was "to do right by the victims of the economy while doing right by the taxpayers. A bed for the night is a help, but it is not a solution, especially for families."

A 24-hour hot line was established at that time to provide information about assistance available through the shelter program and to facilitate the transition of homeless persons into the new system. The hot line has continued to provide help to people seeking shelter and other emergency services.

The change in the program resulted in the closing of a number of shelters that had been established in churches a few months earlier. The City, however, continues to contract with several private agencies, including the Salvation Army, St. Vincent de Paul Society, Hospitality House, and the Episcopal Sanctuary for the Homeless, to operate an emergency back-up shelter for homeless persons who do not qualify for General Assistance. In addition, the City provides cots, blankets, sleeping bags and laundry service to shelters operated by other agencies or churches.

In addition to food and shelter, various support services are provided to homeless persons in San Francisco. These include counseling, job training, referrals to appropriate service agencies, alcohol treatment, drug rehabilitation, financial management, reunification and stabilization of families, adult and child protective services, assistance in procuring SSI and other public benefits, and medical and mental health services. Many of these services are provided through the San Francisco Department of Social Services.

A number of agencies provide health care to homeless persons in the city. Each of the shelters is staffed two nights per week by nurses from the University of San Francisco. An open clinic is maintained by the St. Anthony's Foundation. San Francisco General Hospital, which has specialized clinics and psychiatric emergency services, and the Central Emergency Hospital, located near many of the shelters, serve many homeless persons.



Approximately eight percent of all the persons admitted to San Francisco General Hospital in the first quarter of 1983 were identified as being homeless; more than five percent of the persons treated by Central Emergency Hospital in the first six months of 1983 were homeless. Over nine percent of all persons treated for sexual assault by the hospitals in the first three quarters of 1983 were identified as homeless.

By the end of February 1984, 14 months after the Mayor's Shelter for the Homeless Program was initiated, about 268,000 nights of shelter had been provided to the city's most needy citizens. It is estimated that during that time over \$50 million were spent in the city to provide assistance to homeless persons. This includes expenditures for General Assistance, emergency food and shelter programs funded with City and federal monies, medical and psychiatric services, and in-kind contributions by agencies. Over \$750,000 in local tax funds were initially used to finance the shelter program. In April, 1983, the City allocated an additional \$620,500 to continue funding a reduced number of private agencies to provide shelter to homeless persons who do not qualify for General Assistance. In 1983, San Francisco spent \$18.6 million in City funds to provide General Assistance to needy people, including homeless persons.

With the support of Mayor Feinstein, in March 1983 the City allocated \$383,414 in local funds to establish a pilot jobs program for homeless persons. Through this effort, 100 homeless individuals were paid about \$900 a month for clerical and maintenance jobs with the City government. The program was designed to provide participants with recent job experience and income to augment their chances of finding unsubsidized jobs. When the original funding for the program ran out, an additional \$191,600 in Community Development Block Grant funds were allocated to enable 41 of the participants to continue in their jobs. In February, 1984, the final 24 trainees completed the program.

A major campaign was also initiated in January 1983 by Mayor Feinstein to raise money from the private sector to aid homeless people in the city. The Mayor's Fund for the Homeless was established to serve as "a permanent vehicle for channeling contributions to the city's non-profit shelter agencies which have worked with the Mayor's Task Force on the Homeless." Well-known entertainers, civic leaders and persons from the media helped Mayor Feinstein launch the drive; free rock-concerts were held at which cash and food donations were collected for homeless people. Approximately 45 billboards encouraging public support of the Fund were displayed around the city. To date, approximately \$200,000 have been collected through the Mayor's Fund for the Homeless, with donations ranging from a one dollar bill from a child to large checks from national corporations. All of the money has been earmarked to provide direct services to homeless people, included counseling and job placement; none will go for administrative costs.





## Unmet Needs

In the last quarter of 1983, 2,270 persons in San Francisco were turned away from shelters because of lack of space and resources. As part of the significant effort it has undertaken since 1982 to help meet the demand for shelter and other emergency assistance, the City has increased the number of hotels available to homeless persons. As a result, the number of people turned away has decreased this year; during the first quarter of 1984, 382 persons who requested assistance were not served. Local officials indicate that, although the City provides shelter to all persons who requests such assistance, there are many homeless individuals living in cars, in the streets, in abandoned buildings and in the parks of San Francisco.

According to city officials, even though there are many excellent programs currently available to assist homeless persons, there is a lack of services required to meet the immediate and long-term needs of this population. Specifically, the officials say, there is a tremendous need for low-cost housing, for more support services for homeless mentally ill persons, for more alcohol and drug rehabilitation programs, for more mental health and medical services, for employment training, development and placement programs, and for more unskilled non-technical jobs. Federal and state cutbacks in these programs, as well as increased tightening of eligibility requirements for federal assistance programs such as AFDC, food stamps, and disability, are considered to be major reasons why homeless persons do not receive the help they need.

The problem of homelessness in San Francisco is not expected to improve in the near future. "As long as poor economic conditions, high unemployment rates, and inadequate levels of federal and state assistance programs continue," city officials say, "the only anticipated change would be an increase in the number of persons seeking shelter and other emergency services." Local agencies, the officials caution, have already been "sorely strained in trying to provide needed services to homeless persons." As Mayor Feinstein has stated, "San Francisco has responded fully to the problem, but we have reached our limit. Not one city can be expected to solve the problems of the homeless." More assistance from the federal and state governments is clearly needed for the problem of homelessness to be adequately addressed in this country.





## Appendix 3.2

### Directory of Services for Homeless Persons San Francisco, 1984

#### HOTLINES (24 Hours Service)

Fire, police, ambulance	911
Police Department (Non-emergency)	533-0123
S. F. County Jail	553-1441
M.A.P. (Mobile Assistance Patrol)	431-7400
Suicide Prevention	221-1423
Poison Control	666-2845
Drug Hotline	752-3400
Alcohol Hotline	563-5400
Senior Citizen Information Line	558-5512
Rape Hotline	647-RAPE
Kid's Hotline	441-KIDS
Parent's Hotline	826-0800
Haight-Ashbury Switchboard	621-6211
Mental Health Hotline	357-5100
Mental Health Crisis Line	673-6799
Community Crisis Service	567-6600
Runaway Hotline (National)	1-800-621-4000
Peace of Mind (Youth)	1-800-231-6946
Huckleberry House (Youth)	621-2929
Hospitality House	776-2103
Emergency Housing Hotline	431-7300
Night Ministry	986-1464
National Handicap Hotline	1-800-426-4263
Women, Inc. (battered women/children)	864-4722
Bay Area Women's Resource Center	474-2400
Women's Switchboard	431-1414

#### MEDICAL/EMERGENCY

Central Emergency, 50 Ivy Street	558-5432 (24 hours)
San Francisco General Hospital, 1001 Potrero Street	821-8200 (24 hours)
St. Anthony's Free Clinic, 45 Jones Street	864-0241
North of Market Senior Center, 333 Turk Street,	885-2274
South of Market Health Center, 551 Minna	626-2951
District Health Center #4, 1490 Mason at Broadway	558-3158
V.A. Hospital, 4150 42nd at Clement	221-4810
V.D. Clinic, 250 4th Street	558-3804
Haight-Ashbury Free Clinic, 558 Clayton Street	431-1714
Women's Needs Center, 1825 Haight Street	221-7371
The AIDS Center, 54 10th Street	864-4376
Hearing Society of the Bay Area, 1428 Busch, TTY	776-DEAF



## Appendix 3.2

### FOOD

St. Anthony's Dining Room, 45 Jones St., 10 A.M.-12:30 P.M. daily  
Glide Church, 330 Ellis Street, 5 P.M.  
Martin de Porres, 2826 23rd Street, Monday-Saturday, 6-7 A.M.,  
2:30-5:30 P.M., Sunday 9-10:30 A.M.  
One Mind Temple, 351 Divisadero Street, 1-2:30 P.M. Wednesday,  
2-2:30 P.M. Sunday (Vegetarian)  
Lifeline Mission, 917 Folsom Street, meal after services at 6 P.M.  
S.F. Gospel Mission, 219 Sixth Street, soup after services at 6 P.M.

### SHELTER

City Shelter Hotline 431-7300  
Canon Kip (Episcopal Church Sanctuary), 75 Natoma St., men, women and children  
Salvation Army, 75 McCoppin St., men only, 7 P.M.  
St. Vincent de Paul, (Ozanam Center), 1175 Howard Street, 9:30 P.M.  
S.F. Gospel Mission, 219 Sixth Street, men, 6 P.M.  
Lifeline Mission, 917 Folsom Street, men, 21 beds, 6:30 P.M.  
Old St. Mary's Church, 660 California Street, women with children,  
3 night max, 5 P.M.  
Raphael House, 1065 Sutter Street, women with children 474-4621  
La Casa de las Madres, shelter for battered/threatened women, call 469-7650  
Hospitality House, 146 Leavenworth Street, youth: 12-8:00 P.M., men: 11 P.M.  
Huckleberry House, 1292 Paige Street, must call first 621-2929  
St. Anthony's Drop-in Center, 121 Golden Gate, 11 PM: women and children  
Traveler's Aid Society, 38 Mason Street, less than 45 days in S.F.,  
9-12 AM, 1-4 PM, M-F 781-6738  
Night Ministry, limited referrals for couples and families 986-1464

### FREE CLOTHING

Hospitality House, 146 Leavenworth Street  
St. Anthony's, 121 Golden Gate Avenue, 9-10 AM  
S. F. Gospel Mission, 219 Sixth Street  
Clothes Closet, 1680 Mission Street, AFDC families only

### FREE SHOWERS AND SHAVE

Aquatic Park, the foot of Polk Street by the Bay, enter at beach side,  
8:30 A.M. - 4:30 P.M. daily  
Hospitality House, 146 Leavenworth, sign up at noon for use of YMCA showers  
Ozanam Center, 1175 Howard Street, 8-10:30 A.M. Tuesday, Thursday, Saturday  
St. Anthony's, 45 Jones Street near Golden Gate, 1 change of clothes  
washed while shower: Women, 4-6 P.M.  
Men, 7-9 P.M.  
Barber shop M-F, 2-6 P.M.



## Appendix 4

### Job Descriptions

#### Project Director

The duties of the Project Director will include:

- assure integration of the program in the Department of Public Health system
- provide direction to the Department's long-range efforts to improve health care for the homeless
- negotiate contracts or agreements with service providers
- serve as Medical Director for the physicians and nurse practitioners in the shelter clinics
- supervise ongoing collection of data regarding the medical problems of the homeless
- provide direct patient services



Appendix 5

Letters of Agreement from Participating Agencies





ST. ANTHONY FOUNDATION  
MEDICAL CLINIC

55 Jones St., San Francisco

OFFICE:  
121 Golden Gate Ave.,  
San Francisco, CA 94102  
864-0241

Fr. Alfred Boeddeker, O.F.M.  
Founder

Fr. Floyd Lotito, O.F.M.  
Director, Dining Room

James Kilty, M.S.  
Executive Director, S.A.F.

June 25, 1984

BOARD OF DIRECTORS

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Francis J. Curry, M.D.  
Former Director of Public Health, S.F.  
Professor of Medicine, U.C.S.F.

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St. Mary's Medical Center, S.F.  
George Hunt  
Director of Ambulatory Services  
Pacific Medical Center, S.F.  
Marty Strom  
Business Manager, Clinics  
Pacific Medical Center, S.F.  
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Maylian Lee, R.N.  
Supervising P.H.N.  
Health Center #4  
Dennis Stone, M.D.  
Director, Curry M.S.S.P. Clinic

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Doctor Brickner:

The descriptive narrative in the application of the San Francisco Department of Public Health for funds from the Robert Wood Johnson Medical and Mental Health Program for the Homeless in the United States accurately describes the conditions of these individuals in the central area of this city. The program outlined by Dr. John Kelly will effectively treat the medical, mental health and social needs of these unfortunate human beings. We endorse this program and we will work with Dr. Kelly to assist him to successfully achieve the goals the Department has established.

We recommend this application for your serious consideration and hope that you will fund it, because the program will put together a system of services to resolve the "Homeless Problems."

Sincerely,

*Francis J. Curry, M.D.*

Francis J. Curry  
Administrator and  
Medical Director  
St. Anthony Clinic



# The Salvation Army

San Francisco Harbor Light Services  
1275 Harrison Street (415) 864-7000  
San Francisco, California 94103

June 29, 1984

Dr. John J. Kelly, M.D.  
City & County of San Francisco  
Department of Public Health  
101 Grove Street, Suite 323  
San Francisco, CA 94122

Dear Dr. Kelly:

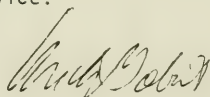
This is to certify that The Salvation Army Harbor Light Services, the agency responsible for the Shelter for Homeless Men at 341 Eddy Street, is willing to support to the utmost your proposal in order to furnish medical help and other ancillary services to the homeless population.

You can be assured of the cooperation of our staff at that location and we will be more than happy to make our facility available on a mutually convenient and scheduled basis.

Thank you so much for caring about those who are less fortunate than ourselves.

In His Service.

Cordially,



Nick Gabriel M.B.A., A/Captain  
Director

NG:clw







June 28, 1984

Dr. John T. Kelly, M.D.  
101 Grove, Room 323  
San Francisco, CA 94102

Dear Dr. Kelly,

This letter will confirm that the St. Vincent de Paul Society will provide space at our shelter at 1175 Howard Street for on-site medical visits. Our staff will be happy to cooperate in every way and very much appreciate the opportunity to work with you to better serve our homeless population.

We look forward to the program's commencement. Thanks again for all your efforts.

Sincerely,

T. Kevin Gagen  
Shelters Program Director  
St. Vincent de Paul Society

**Administrative Office** 1745 Folsom Street San Francisco, CA 94103 (415) 863-3315

**Oliver House** 80 Ninth Street San Francisco, CA 94103 (415) 621-5286

**Ozanam Reception Center** 1175 Howard Street San Francisco, CA 94103 (415) 864-3057

**Rosalie House** 1745 Folsom Street San Francisco, CA 94103 (415) 626-1515

**St. Vincent de Paul Shelters** 1173 Howard Street San Francisco, CA 94103 (415) 864-3057

**St. Vincent de Paul Stores & Rehabilitation** 1745 Folsom Street San Francisco, CA 94103 (415) 626-1515





CENTRAL CITY

# HOSPITALITY HOUSE

146 Leavenworth Street  
San Francisco, California 94102  
(415) 776-2102

**Gabriel Gesmer**  
President

**Colesia Sterling**  
1st Vice President

**Jerry Burke**  
2nd Vice President

**Eileen Bleeker**  
Secretary

**Edward Jay**  
Treasurer

**David Cincotta**  
**Tom Harris**  
**Susan Cook Hoganson**  
**Herb Kregel**  
**Ann Krivonic**  
**Larry Long**  
**Gilbert Lopez**  
**Harry Mack**  
**Mark Powelson**  
**Gloria Root**

**Barbara Bysiek**  
Executive Director

June 28, 1984

John Kelly, M.D.  
Director, M.I.A. Program  
San Francisco Dept. of Public Health  
Room #33  
101 Grove  
San Francisco, Ca.

Dear Dr. Kelly;

This letter is intended to formalize the agreement between the San Francisco Department of Public Health and Central City Hospitality House.

Central City Hospitality House will furnish space for the San Francisco Department of Public Health staff and we look forward to working with you in providing a coordinated system of medical and psychiatric services to the homeless through funding from the Robert Wood Johnson Foundation.

Sincerely,

Barbara Bysiek, L.C.S.W.  
Executive Director

BB:hj





# the episcopal sanctuary

174 Eighth Street at Natoma, San Francisco, California 94103 415-863-3893

*A non-profit charitable organization which shelters and feeds, clothes, counsels and rehabilitates  
jobless and homeless individuals, without regard to race, religion or sex.*

The Rt. Rev. William E. Swing, D.D.  
Chairman of the Board

Executive Members of the Board:

Kenneth B. Weeman Jr.  
President

Elizabeth E. Moore  
Vice-President

Peter J. Musto  
Treasurer

Kathryn Weeman  
Secretary

Phillip C. Smith  
Counsel

Gary L. Hultquist  
Counsel

The Rev. William H. Barcus III, M.Div.  
Executive Director

June 29, 1984

John T. Kelly, M.D.  
Medical Director  
Medically Indigent Adult Program  
101 Grove  
San Francisco, Ca 94102

Dear Dr. Kelly,

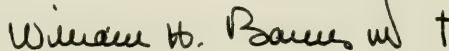
*We very much look forward to cooperating with  
the Department of Public Health in its sheltercare  
program. An on-site clinic is a critical need for  
our clients, and we agree to make the space available  
for clinical activities sponsored by the department.*

*We welcome this opportunity to provide direct medical  
assistance to the homeless people who use our shelter,  
as was provided before at Grace Cathedral under your  
direction.*

*We stand ready to make available the services of our  
staff, including our social workers and their referral  
network, to improve the lot of our clients in whatever  
ways are possible.*

*Our cooperative efforts with you and the Department  
of Health have been of enormous benefit to our clients  
and, of equal importance, to the city. Thank you.*

Sincerely,



The Rev. William H. Barcus III

cc: Board of Directors  
The Rt. Rev. William E. Swing Jr.



ST. ANTHONY FOUNDATION  
MEDICAL CLINIC

55 Jones St., San Francisco

OFFICE:  
121 Golden Gate Ave.,  
San Francisco, CA 94102  
864-0241

Fr. Alfred Boeddeker, O.F.M.  
Founder

Fr. Floyd Lotito, O.F.M.  
Director, Dining Room

James Kilty, M.S.  
Executive Director, S.A.F.

June 25, 1984

BOARD OF DIRECTORS

Chairman:

Francis J. Curry, M.D.  
Former Director of Public Health, S.F.  
Professor of Medicine, U.C.S.F.

Vice-Chairmen:

Frank Solomon, M.D., FACP  
Director of Out-Patient Services  
St. Mary's Medical Center, S.F.  
George Hunt  
Director of Ambulatory Services  
Pacific Medical Center, S.F.  
Marty Strom  
Business Manager, Clinics  
Pacific Medical Center, S.F.  
Cecilia Johnson, M.D.  
District Health Officer  
Maylian Lee, R.N.  
Supervising P.H.N.  
Health Center #4  
Dennis Stone, M.D.  
Director, Curry M.S.S.P. Clinic

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Doctor Brickner:

The descriptive narrative in the application of the San Francisco Department of Public Health for funds from the Robert Wood Johnson Medical and Mental Health Program for the Homeless in the United States accurately describes the conditions of these individuals in the central area of this city. The program outlined by Dr. John Kelly will effectively treat the medical, mental health and social needs of these unfortunate human beings. We endorse this program and we will work with Dr. Kelly to assist him to successfully achieve the goals the Department has established.

We recommend this application for your serious consideration and hope that you will fund it, because the program will put together a system of services to resolve the "Homeless Problems."

Sincerely,

*Francis J. Curry, M.D.*

Francis J. Curry  
Administrator and  
Medical Director  
St. Anthony Clinic





# Larkin Street Youth Center

*a multi-service center for homeless, runaway and street youth*

1040 Larkin Street  
San Francisco, California  
94109

(415) 673 0911

June 28, 1984

John T. Kelly, M.D., ph.D.  
Department of Public Health  
101 Grove Street, Room 323  
San Francisco, California 94102

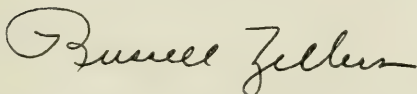
Dear Dr. Kelly:

I am pleased to submit this letter of agreement pertinent to health services for homeless clients at the Larkin Street Youth Center. The Larkin Street Youth Center is a multi-purpose center for homeless, runaway and street youth. The Center is located in proximity to the central city and Polk Street neighborhoods, areas where these young people congregate.

Health services for this population has been identified as one of the major service needs of our population of young people.

We are pleased to be included in San Francisco's proposal to the Robert Wood Johnson Foundation's Health Care for the Homeless Program. We will be able to provide the space to operate a health clinic at Larkin Street and are happy to have the opportunity to work with the San Francisco Department of Public Health in this endeavor to serve a very needy population in our city.

Sincerely,



Russell Zellers, MSW  
Program Director

RZ:jd



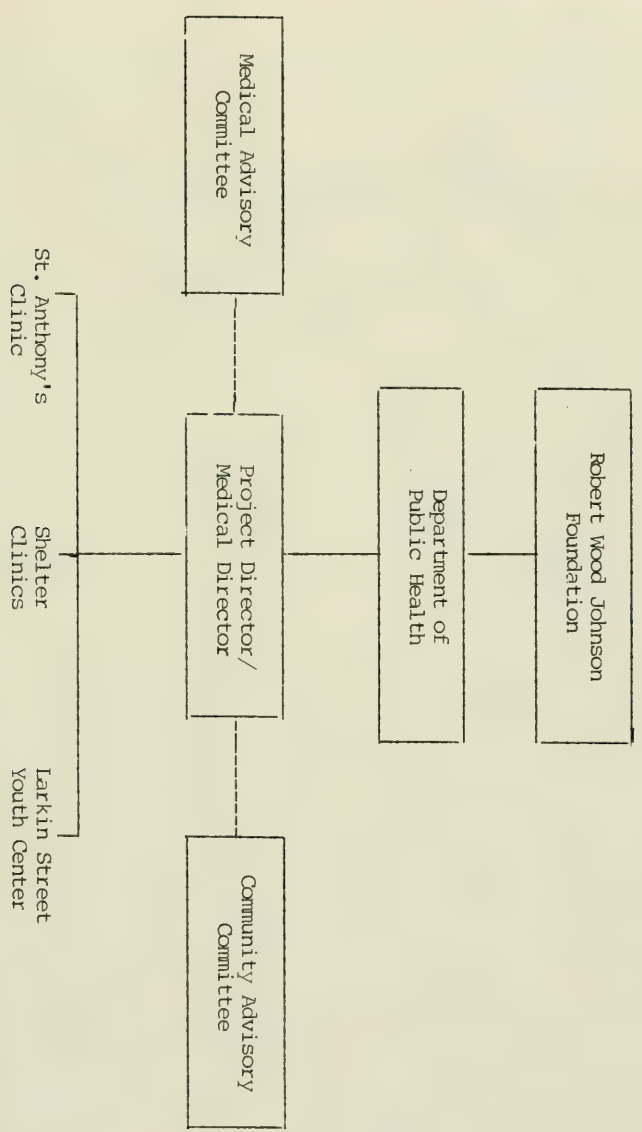
## Appendix 6

### Organizational Chart





Administrative Structure





Appendix 7

Training Program for Shelter Providers

Sponsored by

Northeast Mental Health Center

June, 1984



# SCHEDULES

## SHELTER PROVIDER'S TRAINING PROGRAM\*

SPONSORED BY

NORTHEAST MENTAL HEALTH CENTER

(415) 558-4031

\* This Training Program is Opened to All Shelter Providers.

<u>Date</u>	<u>Time</u>	<u>Topics</u>	<u>Sites</u>	<u>Presenters</u>
June 13, 1984	10:00 am - 12:00 pm	Violence Defusion	Hospitality House	1) Lt. Phillip Dunnigan 2) Kitty Ryan
June 13, 1984	4:30 pm - 6:30 pm	Violence Defusion	St. Vincent De Paul Episcopal Sanctuary	1) Lt. Phillip Dunnigan 2) Kitty Ryan
June 19, 1984	3:00 pm - 4:00 pm	Suicidal Issues	S. F. Support Services	1) David Fariello 2) Christine Seeger, M.D.
June 20, 1984	10:00 am - 12:00 pm	Stress Management	Salvation Army	1) Lt. Phillip Dunnigan 2) Kitty Ryan
June 20, 1984	5:00 pm - 7:00 pm	Violence Defusion Stress Management	Episcopal Sanctuary 174 8th Street , S.F.	1) Lt. Phillip Dunnigan 2) Kitty Ryan
June 20, 1984	5:30 pm - 7:00 pm	Suicidal Issues	Salvation Army 341 Eddy Street San Francisco	1) Diane Adams, Ph.D. 2) Pern Hunt 3) Christine Seeger, M.D. 4) David Fariello
June 21, 1984	10:30 am - 12:30 pm	Suicidal Issues	Hospitality House 146 Leavenworth San Francisco	1) Diane Adams, Ph.D. 2) David Fariello 3) Pern Hunt
June 21, 1984	5:00 pm - 6:30 pm	Evaluation/Assessment of Mental Health	St. Vincent de Paul 1175 Howard Street (Dormitory) S. F.	1) David Fariello 2) Pern Hunt
June 21, 1984	5:30 pm - 7:30 <sup>0</sup> pm	Communication and Interview Techniques	Salvation Army 341 Eddy St., S.F.	Diane Adams, Ph.D.
June 22, 1984	5:00 pm - 7:00 pm	Stress Management Violence Defusion	Salvation Army 341 Eddy St., S.F.	1) Lt. Phillip Dunnigan 2) Kitty Ryan



# SCHEDULES

## SHELTER PROVIDER'S TRAINING PROGRAM\*

SPONSORED BY

NORTHEAST MENTAL HEALTH CENTER  
(415) 558-4031

\* This Training Program is Opened to All Shelter Providers.

<u>Date</u>	<u>Time</u>	<u>Topics</u>	<u>Sites</u>	<u>Presenters</u>
June 25, 1984	11:30 am - 1:00 pm	Violence Defusion	2069-A Mission San Francisco	1) Lt. Phillip Dunnigan 2) Kitty Ryan
June 26, 1984	3:00 pm - 4:00 pm	Crisis Intervention	S. F. Support Services 420 Jones San Francisco	1) David Fariello 2) Phern Hunt 3) Christine Seeger, M.D.
June 26, 1984	7:00 pm - 9:00 pm	Issues on Contacting Family of Run Aways	Diamond Youth Center 110 Diamond St., S.F.	Paul Gibson
June 27, 1984	10:00 am - 12:00 pm	Violence Defusion	S.F. Support Services 420 Jones St., S.F.	1) Lt. Phillip Dunnigan 2) Kitty Ryan
June 27, 1984	10:00 am - 12:00 pm	Crisis Intervention	Hospitality House 146 Leavenworth San Francisco	1) David Fariello 2) Phern Hunt 3) Christine Seeger, M.D.
June 27, 1984	5:00 pm - 7:00 pm	Assessment of Mental Health Child Abuse Issues Suicidal Issues	Episcopal Sanctuary 174 8th Street San Francisco	1) Christine Seeger, M.D. 2) Diane Adams, Ph. D.
June 28, 1984	To be arranged			Frank Lipton, M.D.
June 28, 1984	12:00 pm - 1:30 pm	Stress Management	2069-A Mission San Francisco	1) Lt. Phillip Dunnigan 2) Kitty Ryan
June 28, 1984	5:00 pm - 6:30 pm	Stress Management Evaluation/Assessment of Mental Health	St. Vincent de Paul 1175 Howard St., S.F.	1) Diane Adams, Ph.D. 2) Christine Seeger, M.D.
June 29, 1984	To be arranged			Frank Lipton, M.D.
June 30, 1984	To be arranged			Frank Lipton, M.D.





## Appendix 8

### Letters of Endorsement





June 28, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Dr. Brickner:

I am writing to request your approval of the San Francisco Department of Public Health's application to the Health Care for the Homeless Program, sponsored by the Robert Wood Johnson Foundation and the Pew Memorial Trust.

As the provider of last resort in San Francisco, the Department provides a broad range of medical and psychiatric services to thousands of indigent patients each year. Many of these patients are homeless.

The Department generally provides services to the homeless whenever they present at our facilities. However, we have never had a program designed specifically for the homeless.

The Department's proposal to establish an outreach system for the homeless, to deliver on-site medical and mental health services, should significantly increase the accessibility of health care to the homeless in San Francisco. The funding of our proposal should greatly help us in our long-range efforts to obtain additional resources to provide for the health needs of the homeless.

I urge you to give our proposal your most serious consideration.

Sincerely,

A handwritten signature in dark ink, reading "Mervyn F. Silverman", is written over a horizontal line.

Mervyn F. Silverman, M.D., M.P.H.  
Director of Health

MFS:cpc





June 28, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the  
Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical  
Center  
153 West 11th Street  
New York, N.Y. 10011

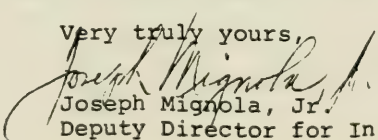
Dear Dr. Brickner:

I have served on the Mayor's Task Force for the Homeless for the past nineteen months. During this period of time, the organizations concerned with the feeding, clothing and sheltering of the homeless were brought together. As the representatives of the various groups have worked with the City and County of San Francisco to better meet the needs of the homeless, we have found a much higher incidence of illness among the homeless than in the general population. Great numbers of the homeless in San Francisco have histories of mental illness, substance abuse and physical disability.

In looking at the health care services provided to the homeless, it has become apparent that the homeless are heavy users of health care services but, generally, they do not access medical care until their problems have become serious. There would be considerable mutual benefit - to the health providers and the homeless - if there could be earlier intervention.

The most likely way in which the delivery of health care services to the homeless could be improved would be through the development of an outreach system which would put health personnel into the shelters. The Department of Public Health does not have the resources to create such a system. However, this system would be established if our proposal to the Rober Wood Johnson Foundation and Pew Memorial Trust is approved. Approval of our application would greatly improve the delivery of medical care to the homeless and should lead to improvements in the health and well being of a significant number of the homeless.

Very truly yours,

  
Joseph Mignola, Jr.  
Deputy Director for Institutions





June 29, 1984

Philip W. Brickner, M.D., Director  
Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, New York 10011

Dear Dr. Brickner:

I am writing in support of the City of San Francisco's application to the Robert Wood Johnson Foundation/Pew Memorial Trust Healthcare for the Homeless program.

As the Director of Inpatient and Emergency Psychiatric Services at San Francisco General Hospital, the County's only publicly-funded inpatient psychiatric facility, the problems of the homeless mentally ill have been of great concern to me for some time. The effect of homelessness and residential instability on both the level of need and presenting characteristics of the patients we see led me in fact to engage in several research studies in this area (cf. Chafetz, L. and Goldfinger, S. Residential Instability in a Psychiatric Emergency Setting, Psychiatric Quarterly, 56:1 (1984). More recent, albeit less rigorous, follow up has, I believe, demonstrated the impact of the organized shelter system developed since the time of the original research data collection. It is clear, however, that the existence of free-standing shelters addresses only part of the problem.

As a member of the American Psychiatric Association Task Force on the Homeless Mentally Ill, I have over the past year had the opportunity to visit the shelter systems in many of America's major cities. The site visit group, composed of H. Richard Lamb, M.D., Leona Bachrach, Ph.D., Frank Lipton, M.D., Ellen Baxter, myself and others, spent many hours discussing the contrast between the approach to shelter care delivery in various communities. Although everyone agreed that San Francisco offered the most coordinated approach to service delivery, it was apparent that even here the clients suffered from the lack of full availability and accessibility to medical and mental health care interventions.





Philip W. Brickner, M.D.  
June 29, 1984  
Page Two

It is from this perspective that I can most enthusiastically endorse Dr. Kelly and the Department of Public Health's proposal. They have carefully assessed both the medical and mental health needs and current service utilization patterns of the homeless population. Rather than arriving at a service delivery model from an external perspective, they have weekly, and for more than a year, met with all shelter providers in this City and County. Thus, their service model reflects the expressed needs, preferences and "hands-on" knowledge of those most centrally involved in the existing shelter system. Because of the care and dedication demonstrated by them, I know that the program is welcomed, endorsed and earnestly supported by all those who work closely with this population.

I recognize that the selection of fourteen cities in the Country for the receipt of program funding is an unenviable task. One might make the case that San Francisco, already in possession of a relatively-coordinated and comprehensive system, could be considered as an area of lower priority. I believe however, that in the interests both of furthering our understanding of the specific medical needs of the homeless population and in the interests of maximizing the potential knowledge that can be gained in developing service systems for those clients, I believe that San Francisco would serve as a superb site for a demonstration project. I can therefore enthusiastically, and without reservation, endorse this proposal.

Please feel free to contact me if I can be of any further assistance.

Sincerely,



Stephen M. Goldfinger, M.D.

Director

Outpatient and Emergency Services  
San Francisco General Hospital

Assistant Clinical Professor of Psychiatry  
University of California San Francisco

Member

American Psychiatric Association  
Task Force on the Homeless Mentally Ill

SMG:maj





June 25, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Dr. Brickner:

I am writing to let you know of our support for the application of the San Francisco Department of Public Health for financial support from the Robert Wood Johnson Foundation for a program offering better coordinated and more comprehensive Health Care For the Homeless.

A number of CMHS staff have participated in coordinating existing health services for the homeless, and in planning this program proposal. We have learned that the homeless receive tremendous amounts of expensive psychiatric inpatient care. Often this care is not the most useful or relevant, and it is regularly influenced by the lack of food, clothing and shelter, and by inadequate earlier health care.

We are eager to continue to work together to develop the best possible network of services for this very difficult group of San Franciscans. Our estimates are that as many as one-third of the homeless have primary mental illnesses which account for their confusion and their difficulty in documenting their psychiatric disabilities and their eligibility for financial assistance and appropriate health care.

This is a major, and increasing, problem in San Francisco. We have had real success in building cooperative networks but now need to increase programs in order to reduce the inappropriate use of the most expensive acute services.

Sincerely,

A handwritten signature in dark ink, appearing to read "Alan Leavitt", written over a horizontal line.

Alan Leavitt, M.A.  
Program Chief

cc: John T. Kelly, M.D., Ph.D.  
Medical Director, MIA Program





June 27, 1984

Phillip W. Brickner, M.D.  
Director of Health Care of the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital & Medical Center  
153 West - 11th Street  
New York, NY. 10011

Dear Dr. Brickner:

I am pleased to support the application of the San Francisco Department of Public Health to The Robert Wood Johnson Foundation's Health Care for the Homeless Program. The proposal outlines well the problems of delivering health care and other support services to the homeless and "street people" of the North of Market area of San Francisco.

As a former Administrator and current Medical Director of the Division of Outpatient and Community Services of San Francisco General Hospital since 1971, I am personally familiar with the difficulties of providing services to this elusive and high-need group of patients. Although our Satellite clinics, based in the community, have made significant improvements in the care to this population, the current demand for services exceeds existing resources by a considerable degree. Our South of Market Health Center, which has been the principal facility serving the population of both North and South of Market for many years has had a 40 percent increase in its workload in the past year. This increase has come from the combination of increase in the homeless population, as well as the shift created by decreased funding for Medically-Indigent Adults, and other low-income populations formerly eligible for Medicaid services.

The situation would be even worse if St. Anthony's Clinic had not been developed directly to serve the North of Market population. However, that facility also is strained and needs intensive work to develop improve services to a population that seems to increase yearly.

Should the proposal be approved, we will work closely with the Shelter Care Project and staff. We believe that a coordinated, community-wide approach to this troubled group of people is the only strategy that is likely to prove successful in the long run.

Sincerely,

A handwritten signature in dark ink, appearing to read "D. Fink", written over the word "Sincerely,".

Donald L. Fink, M.D.  
Medical Director





San Francisco General Hospital  
Medical Center

June 29, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, New York 10011

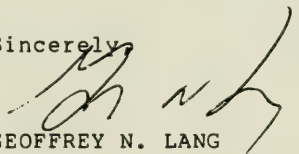
Dear Dr. Brickner:

This letter endorses the Robert Wood Johnson grant application of the San Francisco Department of Public Health for medical services to the homeless.

The access to and continuity of care for the medical and psychiatric needs of the homeless will be well improved by implementation of the "shelter care" program. The linkages that will be developed with San Francisco General Hospital and other health programs are vitally necessary to this group of homeless patients.

I strongly urge your favorable consideration of this grant request.

Sincerely,



GEOFFREY N. LANG  
Executive Administrator

GNL:af







San Francisco General Hospital  
Medical Center

June 22, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, NY 10011

Dear Dr. Brickner:

I am writing in support of the application of the San Francisco Department of Public Health to the Robert Wood Johnson Foundation's Health Care for the Homeless Program.

The Emergency Department at San Francisco General Hospital is a common entry point into the health care system for thousands of homeless persons each year. Lacking food, shelter and transportation, the homeless make the least appropriate use of the Emergency Department. Their patterns of use reflect a lack of insight into their health problems that lead to crisis intervention and poor aftercare. The burden placed on our department to manage health care problems that could have been prevented among the indigents is considerable.

It is essential that outreach programs be created to better address and channel the health needs of our homeless citizens. We are currently without the resources to alter the patterns of neglect which contribute to a marked increase in morbidity and mortality in this group.

I strongly urge your favorable consideration of San Francisco's application.

Sincerely,

A handwritten signature in dark ink, appearing to read "EC Geehr".

Edward C. Geehr, M.D.  
Chief, Emergency Services  
SFGH

ECG/go/wp

cc: John T. Kelly, M.D., Ph.D.  
Medical Director  
MIA Program





June 27, 1984

Philip W. Brickner, M.D.  
Director  
Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital & Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Dr. Brickner:

As Director of the Adult Medical Clinics at San Francisco General Hospital I can attest to the profound needs presented by the homeless in San Francisco. Our medical screening clinic and primary care general medicine clinics receive these patients from the community centers and emergency room with advanced states of illness related to the difficulty in obtaining care. An integrated program emphasizing preventive services, screening and early treatment would clearly reduce the severity of presenting illness and may in fact decrease our hospitalization rate for these patients. The lack of adequate drop-in capabilities in our clinics severely limits access to this particular population. Institutional constraints and the nature of the bureaucracy of a large county institution, as well as the fragmentation of the system in general, compounds these problems.

My staff and I will work closely with Health Care for the Homeless Program in any way possible.

Sincerely,

A handwritten signature in dark ink, appearing to read "Richard H. Fine".

Richard H. Fine, M.D.  
Chief, Adult Medical Clinics  
Associate Clinical Professor of Medicine  
University of California, San Francisco

RHF:ee



# UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

SCHOOL OF MEDICINE  
DEPARTMENT OF PEDIATRICS  
SAN FRANCISCO HIGH RISK YOUTH PROJECT

*Please address reply to the undersigned at*

SAN FRANCISCO GENERAL HOSPITAL  
SAN FRANCISCO, CALIFORNIA 94110  
Room 6B31

June 26, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Dr. Brickner:

It is my pleasure to write this letter of endorsement for the San Francisco Department of Public Health application for the Homeless Project.

As a health provider at San Francisco General, I encounter homeless and runaway youth on a daily basis in my Teen Medical Clinic at San Francisco General Hospital. Those that get to me and my staff are especially motivated and/or needy of medical attention. They present complex and difficult medical and psychosocial problems which often challenge and confound. Since San Francisco is still a gathering point for youth, they bring with them problems for which they were motivated to leave their homes.

The Robert Wood Johnson High Risk Youth staff have been struck with the multiple health problems of these youth in the community. Specially, these young people have been identified at the San Francisco Youth Guidance Center (Juvenile Hall) as well as at Hospitality House and Larkin Street Center in the Tenderloin area of the City.

There is great need for health care provisions in the Polk Street and Tenderloin Districts for these youth. A small medical clinic has been established at Larkin Street recently, but there is great need for further support for the homeless youth in this area.

High Risk Youth Staff would be able to establish the service so that it might continue after the termination of that project. Besides medical providers, the use of a nurse practitioner would expand the provider time at Larkin Street.

The needs are great and it is very hopeful that we can begin a program for homeless youth which would be maintained by the City when once established and developed.

I give my full support for this effort to serve the many homeless people and especially the youth in San Francisco.

Sincerely yours,

A handwritten signature in cursive script that reads "Richard C. Brown".

Richard C. Brown, M.D.  
Director, Adolescent Services, S.F.G.H.





San Francisco General Hospital  
Medical Center

June 26, 1984

Philip W. Brickner, M.D.  
Director Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, New York 10011

Dear Doctor Brickner,

I am writing in support of San Francisco Department of Public Health's application to the Robert Wood Johnson Foundations Health Care for the Homeless.

As social workers within the Public Health System, we are acutely aware not only of the major issues affecting health care delivery to the Homeless but also their impact on our existing system of health care.

We look forward to and are confident that San Francisco can design and implement a health care system responsive to their needs and tailored to provide adequate and continuing care to this growing unique population we have identified and profiled.

Very Truly Yours,

A handwritten signature in cursive script, reading "Jean-Claire Plebani".

Jean-Claire Plebani, MSW  
Chief, Medical Social Services

JCP:dg







*San Francisco Medical Center  
Outpatient Improvement Programs, Inc.*



995 POTRERO AVENUE, SAN FRANCISCO, CALIFORNIA 94110  
P.O. BOX 40519, SAN FRANCISCO, CA. 94140  
(415) 821-8530/8531

**SOUTH OF MARKET HEALTH CENTER**

551 MINNA STREET  
SAN FRANCISCO CA 94103  
(415) 821-8620

**CALEB G. CLARK POTRERO HILL  
HEALTH CENTER**

1050 WISCONSIN STREET  
SAN FRANCISCO CA 94107  
(415) 821-8648

**SOUTHEAST HEALTH CENTER**

2401 KEITH STREET  
SAN FRANCISCO CA 94124  
(415) 822-2850

**CENTRAL CITY DAY TREATMENT**

191 GOLDEN GATE AVENUE  
SAN FRANCISCO CA 94102  
(415) 864-0207

**TENDERLOIN CLINIC**

251 HYDE STREET  
SAN FRANCISCO CA 94102  
(415) 673-5700

June 28, 1984

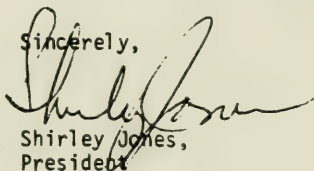
Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Dr. Brickner:

Yesterday, at its regular meeting, the Executive Committee of the Board of Directors of the San Francisco Medical Center Outpatient Improvement Programs, Inc., acting for the Board, voted its endorsement of the application to be submitted by San Francisco requesting funding of a Health Care for the Homeless Project in this city. While many of the details of this proposal remain to be worked out, the basic concept is most appropriate for San Francisco. From our work with the Tenderloin area psychiatric outreach programs, and the South of Market Health Center, there are substantial numbers of homeless people in desperate need of basic medical care. We are fully prepared to cooperate in the development of this vital project.

Please give this request for funding your most serious attention. Thank you for your attention to this matter.

Sincerely,

  
Shirley Jones,  
President

cc: Dr. John Kelly





# North of Market Multipurpose Senior Services

June 28, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, New York 10011

Dear Dr. Brickner,

As the Director of Services for the North of Market Senior Service Center, I am writing in support of the application by the San Francisco Department of Public Health to the Robert Wood Johnson Foundation's Health Care for the Homeless Program.

We are located in the "Tenderloin" neighborhood of San Francisco and serve persons 60 and older in our multipurpose agency and primary care clinic. We are acutely aware of the broad range of health care needs needed by the increasing homeless population in this city. The proposal, as outlined, will provide necessary services which can be implemented in a realistic, coordinated, humanistic way. Please give this proposal your utmost consideration. Thank you.

Sincerely,

Gay T. Kaplan, RN, MSN  
Director of Services

/jff

cc: J. Kelly, MD, PhD

**Francis J. Curry Center**

333 TURK STREET • SAN FRANCISCO, CALIFORNIA 94102 • (415) 885-2274



Member  
Board of Supervisors  
City and County of San Francisco



COMMITTEES:

*Chair:*

HEALTH

*Vice-Chair:*

PUBLIC WORKS

*Member:*

CULTURE AND RECREATION

NANCY G. WALKER

June 29, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless People  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Dr. Brickner,

The Department of Public Health is applying for a \$1.4 million, four-year grant from the Robert Wood Johnson Foundation and the Pew Memorial Trust. The purpose of the grant is to deliver health services to homeless people.

As Chair of the Health Committee of the Board of Supervisors, I have long been aware of the many health services required by the City's homeless population. The San Francisco Department of Public Health has unstintingly attempted to meet those needs, many of which have required expensive hospitalization.

However, many of the costly hospitalizations of these people could have been averted had there been the ability to perform early triage and intervention. The majority of those hospitalizations have resulted from illnesses and conditions directly related to the unsettled life styles of homeless people.

I believe the proposed location of satellite clinics in the shelters and expansion of staffing hours of existing satellite services will effectively deal with that problem.

In my opinion, this proposal is another example of the creative and humane approach this City has been making to address the needs of our most unfortunate citizens. I strongly support the funding of this proposal to enable San Francisco to more effectively provide much needed services to its poor and homeless.

Yours truly,

*Nancy Walker*  
Nancy G. Walker



Louise H. Renne  
Member, Board of Supervisors  
City Hall, Room 235  
San Francisco, California 94102

July 5, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, New York 10011

Dear Dr. Brickner:

I have been advised that the San Francisco Department of Public Health is applying for a \$1.4 million, four-year grant to deliver health services to homeless people.

As Chair of the Finance Committee of the San Francisco Board of Supervisors, I strongly support the program described in the grant proposal.

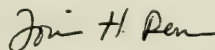
Since December 1, 1982, the City and County of San Francisco has creatively and innovatively provided food, shelter and other services to our City's homeless. The Finance Committee has closely monitored this activity and has provided funding for this effort.

According to information I have been provided by the Health Department, a large number of homeless people have been admitted to San Francisco General Hospital for treatment of illnesses directly related to their homeless condition. Apparently many of those hospitalizations could have been avoided had there been an earlier assessment of the individual health problems of those persons.

I believe the strategy for such early intervention as embodied in this proposal will provide the City the ability to quickly conduct medical evaluations in a more humane manner. Preventive intervention in these cases is the most effective method of addressing the multiplicity of human problems presented by our homeless population.

Again, I strongly support the funding of this application.

Yours truly,



Louise H. Renne, Chair  
Finance Committee

LHR:nm





Member  
Board of Supervisors  
City and County of San Francisco



COMMITTEES:

CHAIR  
PUBLIC PROTECTION  
VICE-CHAIR:  
PLANNING, HOUSING &  
DEVELOPMENT  
MEMBER:  
TRANSPORTATION & TRAFFIC

WILLIE B. KENNEDY

June 18, 1984

Dr. Philip W. Brickner, M.D.  
Director Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Dr. Brickner:

I would like to take this opportunity to express my strong support of the \$1.4 million grant application being made by the San Francisco Department of Public Health.

As Chair of the Planning, Housing and Development Committee of the Board of Supervisors, I conducted lengthy public hearings on the problems of San Francisco's homeless in November, 1982.

At those hearings we learned that a large number of persons admitted to San Francisco General Hospital were homeless. We were told that they required a wide variety of medical services for illnesses and conditions directly related to their homeless status. We also learned that many of those costly hospital admissions would not have been required if there had been a more timely intervention and identification of individual medical needs.

I believe the attached proposal is the most effective and humane method of quickly assessing the medical problems of our homeless population and then providing the therapeutic remedies indicated in the most human and cost effective fashion.

I strongly support this application and urge that it be funded.

Sincerely,

*Willie B. Kennedy*  
Willie B. Kennedy  
Member, Board of Supervisors





OFFICE OF  
THE SHERIFF

MICHAEL HENNESSEY, Sheriff  
WILLIAM A. DAVIS, Undersheriff

Room 333, City Hall  
SAN FRANCISCO, CA 94102  
Administration 558-2411

July 27, 1984

Ref: 84-343

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Mr. Brickner,

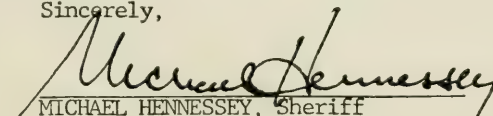
I understand that the San Francisco Department of Public Health is applying for a four-year, \$1.4 million grant to provide health services for homeless people in our community.

As Sheriff of the City and County of San Francisco, I have responsibility for all custody and correctional facilities. As a result, my staff has witnessed firsthand the multitude of medical and mental health needs of homeless people entering our pre-trial facilities. Through no fault of their own, they have completely taxed the jail's medical resources on several occasions with pressing medical and mental health concerns demanding immediate attention. Many of these health problems have been seriously aggravated because they have gone without medical attention for so long.

As an outspoken advocate of the City's efforts to provide for and expand much-needed services to the homeless in our community, I highly commend this innovative grant proposal. In my opinion, this effort is probably the most creative and humanly sensitive of any proposed program in the country today. This proposal, providing for early identification of the personal health needs of homeless citizens at external clinics, is an exemplary approach to addressing the health problems of San Francisco's most needy before they reach a critical stage.

I strongly support funding of this proposal at the level requested. I firmly believe that the inclusion of this project in the City's comprehensive plan for addressing the multiple needs of our City's homeless will significantly enhance the health services my Department and others provide, and most importantly, offer a humane approach to remedying the chronic health problems of the homeless.

Sincerely,

  
MICHAEL HENNESSEY, Sheriff



## United States Senate

WASHINGTON, D.C. 20510

July 5, 1984

Dr. John T. Kelly  
Medical Director  
Medically Indigent Adult Program  
Department of Public Health  
101 Grove Street, #323  
San Francisco, California 94102

Dear John,

Thank you for letting me know of the proposal of the City and County of San Francisco, Department of Public Health, to the Robert Wood Johnson Foundation to develop "Sheltercare" -- a program to provide medical services to homeless persons in San Francisco.

I am familiar with Mayor Feinstein's efforts to address the problems of homelessness in San Francisco and believe that the city has made a tremendous effort to meet the needs of this population. I am pleased to know that the city is now interested in finding ways to improve the availability and quality of health care provided to homeless persons. The city's multifaceted approach in using existing facilities and in coordinating existing services in ways that can better serve homeless persons, and its commitment to provide for all of its needy citizens, should ensure that the city would make a valuable contribution with this timely and important project.

My best wishes for your success with this project. I hope that you will keep me apprised of your progress.

With warm regards,

Cordially,



Alan Cranston





June 27, 1984

Edwin S. Sarsfield  
General Manager

Masaya Kakebe  
Assistant General Manager

Refer to:

Dr. Philip W. Brickner, Director  
Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, NY 10011

Dear Dr. Brickner:

As General Manager of the Department of Social Services, I would like to endorse and strongly support the application from the Department of Public Health to the Robert Wood Johnson Foundation Health Care for the Homeless Program.

Since 1982 I have been actively engaged in the effort to provide the necessities of life for the homeless. My Department has been truly concerned with the plight of the homeless and has placed many of them in shelters, hotels and on General Assistance.

In my experience in working with the homeless, I have found many to be suffering from serious mental and physical disabilities. I am impressed that the Department of Public Health "Sheltercare" program, which would reach out to the homeless, would be of enormous benefit to many unfortunate homeless persons in San Francisco.

The Department of Public Health's program is needed to improve the delivery of health care to the homeless. I strongly urge you to fund San Francisco's application.

Sincerely,

A handwritten signature in dark ink, appearing to read "Edwin Sarsfield", written in a cursive style.

EDWIN S. SARSFIELD  
General Manager  
Department of Social Services





ST. ANTHONY FOUNDATION  
MEDICAL CLINIC

55 Jones St., San Francisco

OFFICE:  
121 Golden Gate Ave.,  
San Francisco, CA 94102  
864-0241

Fr. Alfred Boeddeker, O.F.M.  
Founder

Fr. Floyd Lotito, O.F.M.  
Director, Dining Room

James Kilty, M.S.  
Executive Director, S.A.F.

June 25, 1984

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Former Director of Public Health, S.F.  
Professor of Medicine, U.C.S.F.

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Health Center #4  
Dennis Stone, M.D.  
Director, Curry M.S.S.P. Clinic

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Doctor Brickner:

The descriptive narrative in the application of the San Francisco Department of Public Health for funds from the Robert Wood Johnson Medical and Mental Health Program for the Homeless in the United States accurately describes the conditions of these individuals in the central area of this city. The program outlined by Dr. John Kelly will effectively treat the medical, mental health and social needs of these unfortunate human beings. We endorse this program and we will work with Dr. Kelly to assist him to successfully achieve the goals the Department has established.

We recommend this application for your serious consideration and hope that you will fund it, because the program will put together a system of services to resolve the "Homeless Problems."

Sincerely,

*Francis J. Curry, M.D.*

Francis J. Curry  
Administrator and  
Medical Director  
St. Anthony Clinic



JARL WAHLSTRÖM  
GENERAL

WILLIAM BOOTH  
FOUNDER

WILL PRATT  
TERRITORIAL COMMANDER



## The Salvation Army

FOUNDED IN 1865

SAN FRANCISCO CENTER FOR SOCIAL SERVICES  
445 NINTH STREET  
SAN FRANCISCO, CA 94103  
(415) 861-0755

RAY ROBINSON  
DIVISIONAL COMMANDER

HARRY C. de RUYTER  
Director

June 22, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, New York 10011

Dear Dr. Brickner;

Please accept this as a Letter of Endorsement for the application by the San Francisco Department of Public Health to the Robert Wood Johnson Foundation's Health Care for the Homeless Program.

Since February of 1982, I have been the representative for The Salvation Army in San Francisco on the Homeless issue in my capacity as Director for Social Services of The Salvation Army. Time has passed, allowing a constant gain of knowledge on the subject.

Working daily with five Social Workers who see the Homeless for a variety of reasons, we have found that a large percent of this population have ongoing medical and/or psychiatric problems which constantly need to be treated.

Some of these illnesses existed prior to the time of becoming homeless and are now being aggravated, perpetuated by the living conditions. Homelessness also seems to mean that vulnerability to diseases is increased.

Services are rendered very capably by the San Francisco Dept. of Public Health, but the scope is limited due to funding limitations which are now sought to be augmented by the Health Grant.

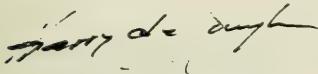
Although the National Commander of The Salvation Army, Commissioner Norman Marshall, serves on the National Advisory Committee for the Foundation, and locally we would have liked to carry out the intent of the Foundation, we deferred to The San Francisco Dept. of Public Health based upon its expertise on the subject.



Currently, The Salvation Army is planning to build a Family Shelter in San Francisco, in which a Medical/Psychiatric unit is incorporated. This unit will be made available to the Department of Public Health to provide a portion of the much needed services. This unit will be integrated with The Salvation Army's Social Workers, who will refer into the Med/Psych, and will accept referrals to provide services beyond the capacity of this unit.  
(Attached please find a program description of services which can be provided.)

We urge strongest consideration for this proposal so that in San Francisco we may continue improving the treatment, physical, mental, and/or social, to the Homeless.

Yours very truly,

A handwritten signature in dark ink, appearing to read "Harry de Ruyter". The signature is fluid and cursive, with a long horizontal stroke at the end.

Harry de Ruyter, Director  
The Salvation Army  
San Francisco Center for Social Services

HdR/sec

Attachments



---

**HEART  
TO GOD**

---



**THE SALVATION ARMY  
SAN FRANCISCO CENTER  
FOR SOCIAL SERVICES**

provides a variety  
of casework, counseling  
and emergency services

to individuals, families and groups on a  
city-wide basis. The professional social  
work staff specializes in advocating for  
clients who are having problems with the  
various public welfare agencies.

**445 NINTH STREET  
SAN FRANCISCO, CA 94103  
HARRY de RUYTER  
DIRECTOR**

**861-0755**

Problems addressed are of psychological, social and/or economic nature. Treatment goals are directed toward intrapersonal and interpersonal problem alleviation and the promotion of constructive, healthy psychosocial development. Client confidentiality is observed.

**COUNSELING**

Task-centered, time-limited  
services are implemented  
when appropriate.

Referral and follow-up  
services are provided  
when indicated.



**HAND  
TO MAN**

---

**ENERGY ASSISTANCE**

R.E.A.C.H., a once a year,  
maximum \$200 grant can be  
issued to persons facing  
utility disconnections.  
Eligibility is determined  
based upon federal poverty  
guidelines.

**EMERGENCY ASSISTANCE**

These services are provided  
on a limited, short term basis to  
individuals and families during  
periods of unexpected economic  
crisis such as life disruption,  
dislocation or other emergencies.  
Primary elements to this service  
include lodging and/or food orders,  
advocacy, counseling and consultation  
with and referral to other community  
service agencies which provide  
extended supplementary aid when  
needed. Efforts are directed toward  
client linkages with employment,  
school and appropriate public income  
maintenance programs.

**INFORMATION AND REFERRAL**

services are provided to  
assist persons securing  
additional and/or supplemental  
aid which is not provided by  
this center. Staff members  
are continuously updated on  
developments of community  
resources including application  
procedures and eligibility  
requirements. Current, active  
resource files are maintained.  
Assessments of requests for  
service, information and referral  
services and follow-up are  
provided when appropriate and  
advocacy actions on behalf of  
the client are exercised as  
needed.

**MISSING PERSONS**

A locating service with a goal to  
reunite family members who have  
become separated.

**ADVOCACY**

Aid in applying for:  
General Assistance (GA)  
Food Stamps  
Medi-Cal  
Supplemental Security Income (SSI)  
Aid to Families with Dependent  
Children (AFDC)







June 27, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, NY 10011

Dear Dr. Brickner:

Since at least 1906, the St. Vincent de Paul Society has provided shelter, food and social services to homeless men, women and children of San Francisco. Our current service level in the Shelters Program is 90 clients per night. Additionally, we have approximately 10,000 client contacts monthly with about 2,000 street alcoholics at our Ozanam Reception Center. I can assure you that a very significant proportion of our clientele is in need of health services not now afforded them.

Clients present themselves at our shelters and at Ozanam with a variety of medical problems. Alcoholism and drug addiction incidence is quite high. Other physical complications of substance abuse, of course, are also seen with great frequency. Psychiatric disorders are pervasive among very many of our clientele. Need for acute medical attention, results of illness or of injury, also is encountered several times daily at our program sites.

Currently, treatment is costly and haphazard -- costly because hospital emergency rooms usually must deal with what could be handled in a clinic setting; haphazard because the medical system can't reach our clientele for on-going treatment as it can more settled and responsible patients.

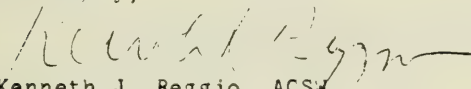
**Administrative Office** 1745 Folsom Street San Francisco, CA 94103 (415) 863-3315  
**Oliver House** 80 Ninth Street San Francisco, CA 94103 (415) 621-5286  
**Ozanam Reception Center** 1175 Howard Street San Francisco, CA 94103 (415) 864-3057  
**Rosalie House** 1745 Folsom Street San Francisco, CA 94103 (415) 626-1515  
**St. Vincent de Paul Shelters** 1173 Howard Street San Francisco, CA 94103 (415) 864-3057  
**St. Vincent de Paul Stores & Rehabilitation** 1745 Folsom Street San Francisco, CA 94103 (415) 626-1515



St. Vincent de Paul Society has consulted with the city's Department of Public Health in the course of its program development of "Sheltercare." We see the goals and objectives of the program as realistic. It's our judgment that funding of "Sheltercare," will result in significant improvement in services to, and ultimately better physical and mental health for, the homeless population of San Francisco.

I'm happy to add my voice of support to the city's application for funding from the Robert Wood Johnson Foundation's Health Care for the Homeless Program.

Sincerely,

  
Kenneth J. Reggio, ACSW  
Executive Director

KJR/sf

cc: John T. Kelly, M.D., Ph.D.





CENTRAL CITY

# HOSPITALITY HOUSE

146 Leavenworth Street  
San Francisco, California 94102  
(415) 776-2102

June 26, 1984

**Gabriel Gesmer**  
President

**Colese Sterling**  
1st Vice President

**Jerry Burke**  
2nd Vice President

**Eileen Blecker**  
Secretary

**Edward Jay**  
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**Ann Krivonic**  
**Larry Long**  
**Gilbert Lopez**  
**Harry Mack**  
**Mark Powelson**  
**Gloria Root**

**Barbara Bysiek**  
Executive Director

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, NY 10011

Dear Dr. Brickner:

I am writing this letter of support to endorse the application of the San Francisco Department of Public Health to the Robert Wood Johnson Foundation's Health Care for the Homeless program.

Central City Hospitality House serves both homeless youth and adults. The adults are served at this address and the youth obtain services both at Central City Hospitality House and at the Larkin Street Youth Center where we are part of a consortium of agencies serving youth.

The homeless are in desperate need of medical and psychiatric services which are located in the Tenderloin. Currently, they must travel across town to San Francisco General Hospital to obtain medical care. Often they do not return to San Francisco General Hospital for follow-up care and only use the hospital when their physical condition requires emergency immediate care. If medical care was available in each of the shelters, and the hours of the medical clinic located at St. Anthony's (a nearby shelter) were increased, the homeless would seek medical care before their physical condition required emergency care. Medical services located in the Tenderloin would certainly result in considerable savings to the city as the cost of hospital-based emergency care is extremely expensive.

Many of the homeless are former mental hospital patients who have been discharged without aftercare planning. A large percentage of the homeless in the Tenderloin have serious psychiatric problems and do not have the inner resources to seek psychotherapy or psychotropic medication. They need mental health services in the shelters where they can avail themselves to medication monitoring, short term psychotherapy and crisis intervention, and referrals to the mental health clinic located in the Tenderloin. Presently, the Tenderloin Mental Health






Clinic is not funded to provide evening and weekend services which are desperately needed.

As a provider of service to the homeless population, Central City Hospitality House is a member of the Mayor's Task Force for the Homeless. The Task Force meets twice monthly and coordinates the services provided to the homeless from both the private and public sector. Central City Hospitality House has been a member of the Task Force since its inception and we wish to continue working cooperatively with other service providers, especially the San Francisco Department of Public Health which is a vital link in the services for the homeless.

The Department of Public Health has provided valuable medical and psychiatric services to the homeless. However, the needs are much greater than their current staff can provide and the additional monies from the Robert Wood Johnson Foundation would result in a comprehensive and cost effective medical program for the homeless.

Yours sincerely,

A handwritten signature in cursive script, reading "Barbara Bysiek".

Barbara Bysiek, L.C.S.W.  
Executive Director  
Central City Hospitality House  
San Francisco

BB:sg





# the episcopal sanctuary

174 Eighth Street at Natoma, San Francisco, California 94103 415-863-3893

*A non-profit charitable organization which shelters and feeds, clothes, counsels and rehabilitates jobless and homeless individuals, without regard to race, religion or sex.*

The Rt. Rev. William E. Swing, D.D.  
Chairman of the Board  
Executive Members of the Board:

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President

Elizabeth E. Moore  
Vice-President

Peter J. Musto  
Treasurer

Kathryn Weeman  
Secretary

Philip C. Smith  
Counsel

Gary L. Hultquist  
Counsel

The Rev. William H. Barcus III, M. Div.  
Executive Director

June 25, 1984

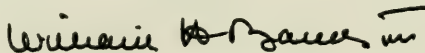
Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, NY 10011

Dear Dr. Brickner:

I am writing to endorse strongly the application of the San Francisco Department of Public Health to the Robert Wood Johnson Foundation's Health Care for the Homeless Program. We are one of the four major shelters, and in fact the largest, which the City of San Francisco utilizes in its care for San Francisco's homeless.

The need for medical assistance, both physical and psychiatric, to our clientele has been overwhelming. I have reviewed carefully the information which Dr. Kelly has sent to you. It is on target, and it is reflective of our experience here at the Sanctuary. Dr. Kelly's proposals will assist us importantly and I thank you for your attention to this proposal. Needless to say, all assistance provided our terribly broken clients will be gratefully appreciated.

Sincerely,



The Rev. William H. Barcus, III, M. Div.  
Executive Director

CC: Dr. John Kelly  
The Hon. Dianne Feinstein

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## CONARD HOUSE ADMINISTRATIVE OFFICES

2441 Jackson Street • San Francisco, CA 94115 • 563-6446

June 26, 1984

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Philip W. Brickner, M.D.

Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Dr. Brickner,

I am very pleased to have the opportunity to endorse a most needed innovative project for the benefit of our homeless in San Francisco. As director of San Francisco Support Services, an agency that houses individuals who are "chronically homeless" with a need to live within a supervised setting, the goal of San Francisco Support Services is to stabilize the clients' living arrangements. This stabilization will lead to fewer arrests and hospitalizations. I believe a significant factor in reversing the expensive revolving door syndrome is available in the shelters' and hotels' medical and psychiatric services provided by sensitive and well-trained professional staff.

Assemblymember Tom Bates, (D-Oakland), Chairman of the Sub-Committee on Mental Health and Developmental Disabilities, on December 11, 1981, held hearings on one of the major mental problems on the 1980's--seriously disturbed young people who are unemployed, uneducated, unskilled, unmarried, mobile, potentially dangerous, and essentially unserved by California's mental health system. "These young people don't use traditional psychiatric treatment," said Bates, "and programs geared specifically to them are new and seriously underfunded. These are people who need assistance in all areas of living--educational, vocational, social, and health needs... The programs that serve them must be as multifaceted as their needs."

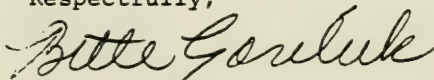


Philip W. Brickner, M.D.

Page two

It is through the Robert Wood Johnson Foundation's Health Care for the Homeless program grant that I see the needs of the homeless being met and resolved.

Respectfully,

A handwritten signature in cursive script, reading "Bette Garelick".

Bette Garelick  
Program Director

cc: John T. Kelly, M.D., Ph.D.  
Robert Solodow, Ph.D.



---

**swords to plowshares: a veterans' rights organization**

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2069A Mission Street  
San Francisco, CA 94110  
415 - 552-8804

June 25, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the  
Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, New York 10011

Dear Dr. Brickner:

Swords to Plowshares is a private non-profit organization which provides social services and counseling for San Francisco veterans. During the 18 month period from December 1, 1982 to May 31, 1984, 61% of the veterans we served were homeless. The majority of these clients stayed in the overnight shelter system supported by a partnership of public and private funds.

Currently, Veterans Administration Hospitals in the Bay Area have followed a policy of providing medical services only to those veterans who have been adjudicated as having "service-connected disabilities." Eighty-five percent of the homeless veterans seen by our staff report health problems, and we approximate that only 7% qualify for Veterans Administration care.

The deterioration of the health of this population has been identified as a major problem as our organization coordinates social services support with the Department of Public Health, City and private agencies. There is a serious need for health services for the homeless in overnight shelters. Increasing the capacity for treatment at sites which currently care for the homeless is also essential.

We strongly endorse the application of the San Francisco Department of Public Health to the Robert Wood Johnson



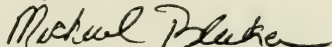


Philip W. Brickner, M.D.  
June 25, 1984  
Page Two

Foundation Health Care for the Homeless Program.

San Francisco service providers are making strong efforts to deal with the emergency conditions of the homeless. At this point the major obstacle in effecting substantive change in in the lives of this group is their overwhelming medical need. There is currently no workable medical network for the homeless.

Sincerely,

A handwritten signature in cursive script, appearing to read "Michael Blecker".

Michael Blecker

MB:jjr



# PRIVATE INDUSTRY COUNCIL

OF SAN FRANCISCO

June 28, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Dr. Brickner:

This letter is written in support of the San Francisco Department of Public Health application for funding under the Robert Wood Johnson Foundation's Health Care Program for the Homeless.

I write based on recent experience.

For a year and a half I have participated as a member of the Mayor's Task Force for the Homeless, first as Director of the Mayor's Office of Employment and Training, and now as private Industry Council President - the new administering agency for employment training. The health professionals and those in the mental health field have discussed their roles, problems, and needs with us in that forum, as members of the Task Force.

We, in this office, obtained federal and local funding in mid 1983 to provide subsidized employment to 123 of the "most employable" of the San Francisco Homeless, in an effort to provide to them a transition from dependency to independence. Over the course of a year we have moved 40 individuals into unsubsidized jobs; there will probably be another half dozen successes by the end of August.

Agencies serving the Homeless selected the "best qualified" for referrals to us, based on their evaluation of the individuals' potential for adjustment to a job. But even with this "creaming" only 37% will have succeeded.

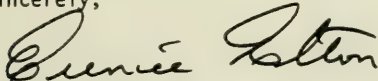
I write, not as a health professional, but also as an experienced member of the job training world, and one with some specialized training in mental health fields.



It is my considered judgement, based on all I have seen and experienced, that by far the majority of the Homeless are persons with moderately severe mental health or (in some cases) physical health problems which may have caused their Homeless status, but surely require remediation before these persons can move successfully into employment in any but the most protected setting.

For these reasons I strongly support the effort of our Department of Public Health and its Medically Indigent program to extend and expand its services in San Francisco to more fully serve the Homeless group. The Homeless are just not going to "make it" without those services.

Sincerely,


A handwritten signature in cursive script, appearing to read "Eunice Elton".

Eunice Elton  
President

EE:ce

cc: Dr. John T. Kelly  
Rotea Gilford





# Larkin Street Youth Center

*a multi-service center for homeless, runaway and street youth*

1040 Larkin Street  
San Francisco, California  
94109

(415) 673 0911

June 25, 1984

John T. Kelly, M.D., Ph.D.  
Department of Public Health  
101 Grove Street, Room 323  
San Francisco, California 94102

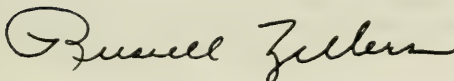
Dear Dr. Kelly:

This letter is in support and endorsement of the application of the San Francisco Department of Health to the Robert Wood Johnson Foundation's Health Care for the Homeless Program.

As the Program Director of the Larkin Street Youth Center, a multi-purpose center for runaway homeless and street youth, I am made aware daily of the desperate needs of homeless people in San Francisco. The numbers of homeless people in San Francisco has increased dramatically in recent years. Their medical, psychological and drug related problems are frequently of the most severe nature.

I want to take this opportunity to commend you on the careful and thoughtful planning process used in the development of San Francisco's proposal for a program of health care for homeless people in San Francisco. These destitute individuals on our city's streets will unquestionably benefit from such a health care program.

Sincerely yours,



Russell Zellers, MSW  
Program Director

RZ:jd







June 28, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

Dear Dr. Brickner:

I am pleased to endorse the proposal for Homeless Health Care Services by the San Francisco Department of Public Health. Dr. Kelly has carefully stated the obvious need for medical/psychiatric services for the homeless population in this City.

In the last 2 years in San Francisco, issues regarding homeless youth have been the focus of a great deal of interest, energy and advocacy. As a result the City now has increased services (including medical) for these youth including: job training program at Hospitality House, Larkin Street Multi-Service Youth Center (food, counseling), and Diamond Street Youth Shelter (food, housing). In terms of medical services, the San Francisco High Risk Youth Project (funded by the Robert Wood Johnson Foundation) has been providing screening histories at Hospitality House for two years and in the last month has opened a medical clinic at Larkin Street for four hours per week. In addition, for the past four months the Division of Forensic Services of the Department of Public Health has operated a 20 hour per week medical clinic at Huckleberry House, which serves status offenders.

If funded, this project would enhance the delivery of medical services at the Larkin Street site. The four hours of services currently provided each week is a start, but barely enough to serve this very needy population. The staff of this clinic would work closely with the other adolescent medicine providers in San Francisco to provide optimal care for follow-up and referral.



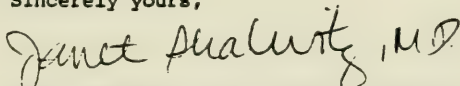
Dr. Brickner/Dr. Shalwitz  
June 28, 1984

page 2

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I applaud the Foundations' efforts in providing care for the underserved people of this country.

Sincerely yours,

A handwritten signature in cursive script that reads "Janet Shalwitz, M.D.".

Janet Shalwitz, M.D., Medical Director  
Youth Guidance Center  
Staff Member, San Francisco High Risk Youth Project  
Assistant Clinical Professor of Pediatrics,  
University of California - San Francisco

JS:ehj





CENTER FOR SPECIAL PROBLEMS  
2107 VAN NESS AVENUE  
SAN FRANCISCO, CALIFORNIA 94109

June 26, 1984

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th Street  
New York, N.Y. 10011

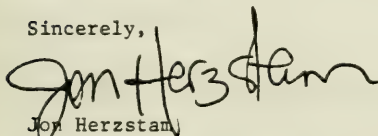
Dear Dr. Brickner:

I am writing to endorse the application of the San Francisco Department of Public Health to the Robert Wood Johnson Foundation's Health Care for the Homeless Program.

Of special interest to me is the youth services component. I wholeheartedly applaud the Health Department in its recognition of the need for specialized services to homeless adolescents. Those of us who have been working with this vastly underserved and largely unacknowledged group of young people know the difficulties this population has faced. We know that their health care problems and needs differ greatly from those of adults. We know that it is next-to-impossible to engage homeless/runaway youth into health care facilities unless those programs are specifically designed for them.

Recently the beginning of a service delivery system has been established for this population of youth in San Francisco. The Health Department has been in the fore-front of this effort along with a variety of community agencies and advocacy groups. Larkin Street Youth Center is the first and most important program in this system and a health care component as described in the application will be an exciting and much needed addition. In fact, I expect it to be a central and primary part of their services.

Sincerely,

  
Jon Herzstam  
Health Program Coordinator

JH:zs



YOUTH EMERGENCY SERVICES  
COALITION

2601 Mission St., #708  
San Francisco, CA 94110  
(415) 641-4362

Philip W. Brickner, M.D.  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital and Medical Center  
153 West 11th St.  
New York, NY 10011

June 27, 1984

Dear Dr. Brickner:

I am writing on behalf of the Youth Emergency Services Coalition to endorse the application of the San Francisco Department of Public Health to the Robert Wood Johnson Foundation's Health Care for the Homeless Program. The Youth Emergency Services Coalition is an influential group of concerned citizens, churches, service providers and community service organizations which advocates for improved services for San Francisco's adolescent homeless youth. We are very impressed that the Health Department's proposal contains a separate component for youth services. We believe that the needs of the adolescent population are unique and that separate services specifically geared to their needs are essential.

San Francisco has initiated a network of services for adolescent homeless and runaway youth. The Health Department has played a leadership role in the development of this network. The health needs of this population are great and we feel it is critical that health services are integrated into the service delivery network.

This proposed program will allow San Francisco to serve a population for whom services have been virtually inaccessible. We urge you to consider San Francisco's application favorably.

Sincerely,



Larry Cruz, Chairman  
Youth Emergency Services Coalition







## COLEMAN CHILDREN & YOUTH SERVICES

1855 Folsom Street, San Francisco, California 94103

Telephone: (415) 861-4582

June 27, 1984

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Philip W. Brickner, M.D.

Director, Health Care for the Homeless Program

Department of Community Medicine

St. Vincent's Hospital and Medical Center

153 West 11th St.

New York, NY 10011

Dear Dr. Brickner

I am writing to you on behalf of the Board of Directors of Coleman Children & Youth Services in support of the San Francisco Department of Public Health's application to the Robert Wood Johnson Foundation's "Health Care for the Homeless" program.

As advocates who have long been involved on behalf of adolescent homeless and runaway youth, we feel it is essential that the program proposed by the Health Department becomes a reality. For too long the grave health needs of this population of youth have been neglected. In addition to remedying this situation, the youth services component of the Health Department's proposal will strengthen the already existing network of services for homeless and runaway adolescents in San Francisco. Through this network, many of these adolescents will be able to benefit right away from the implementation of the specialized health services proposed by the Health Department.

We urge you to give favorable consideration to San Francisco's application.

Sincerely,

Art Tapia

Art Tapia, President

Board of Directors

Coleman Children & Youth Services



**School of Nursing**  
Cowell Hall (415) 666-6681  
June 27, 1984

Philip W. Brickner, M.D.,  
Director, Health Care for the Homeless Program  
Department of Community Medicine  
St. Vincent's Hospital & Medical Center  
153 West 11th Street  
New York, New York 10011

Dear Dr. Brickner:

I wish to submit a letter to endorse the application of the San Francisco Department of Public Health to the Robert Wood Johnson Foundation's Health Care For the Homeless Program.

For the past two years, senior nursing students at the University of San Francisco have participated in an outreach health program for the homeless population in San Francisco as part of their public health nursing course. Utilizing four homeless shelters and St. Anthony's Medical Clinic, students work in a multidisciplinary team headed by Dr. John Kelly, Medical Director, Medically Indigent Adult Program, San Francisco, Department of Public Health and Dr. Francis Curry, Medical Director, St. Anthony's Medical Clinic. Each student establishes a role built on assessment and triage skills; basic first aid; personal and environmental health measures and knowledge of community resources to be used as referrals for clients who mistrust bureaucracies and refuse needed follow-up care.

The homeless population presents challenges to students not found in traditional health care settings. The social problems and health needs are complex and severe and the effects on the community can be devastating. As I bring each student to the homeless shelters to apply their knowledge and nursing skills, I see attitudes towards the clients whether alcoholic, mentally ill, elderly or abused teen agers become caring and compassionate. Drs. Kelly and Curry spend considerable time with the students providing needed information, first aid supplies and medical support. They also encourage students to use their initiative in bringing clients for needed medical care and follow-up health measures.

As more resources become available for providing health and social services on site in the homeless shelters we will continue to make our students part of this important effort to provide compassionate, high quality health care to a very needy, high risk population group.

Sincerely yours,

*Sheila M. Pacheco*  
Sheila M. Pacheco, RN, MS, MPH.  
Instructor-Community Health Nursing

SMP/mg



## Appendix 9

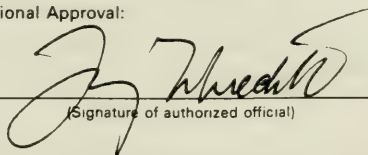
### Request for Project Support



The  
Robert Wood Johnson  
Foundation

P.O. Box 2316  
Princeton, New Jersey 08540  
(609) 452-8701

Request for Project Support  
and  
Conditions of Grant

Title of Project: Sheltercare Program	
Purpose of Project: Improve medical and psychiatric care for homeless persons living in San Francisco	
Applicant Institution:  San Francisco Department of Public Health	Period for which Support is Requested (total project period):  From 1-1-85 Through 12-31-88 (Mo. Day Year) (Mo. Day Year)
Address and Phone Number:	Amount of Support Requested (total project period):  \$1.4 million
*Project Director (name, title, address, phone number):  John T. Kelly, M.D., Ph.D. Medical Director, Medically Indigent Adult Program 101 Grove Street, Room 323 San Francisco, CA 94102 (415) 558-2386	Institutional Financial Officer (name, title, address, phone number):  Larry Meredith, Ph.D. Deputy Director for Operations 101 Grove Street, Room 310 San Francisco, Ca. 94102  Check to be Made Payable to: San Francisco Department of Public Health
<b>Applicant's tax-exempt status:</b> Before the Foundation can take final action on your proposal, we need evidence that your institution is currently a tax-exempt entity, as described in Section 501(c)(3) of the Internal Revenue Code, and is not a private foundation described in Section 509(a). These requirements will be satisfied by your providing us with: (1) a copy of your 501(c)(3) exemption certificate; (2) a copy of Form 4653 or Form 1023 and other data, if any, filed with the Internal Revenue Service. These documents must be accompanied by a letter signed by a responsible officer of your institution certifying that the copies so provided are true and correct copies of the originals on file with your institution and that they remain in full force and effect. PLEASE ATTACH THE LETTER AND THE COPIES OF THESE DOCUMENTS TO THIS FORM. If your institution is not recognized as a tax-exempt entity, briefly describe its organization.  Any questions you may have about your tax-exempt status should be directed to the Foundation officer working with you on your proposal (609/452-8701).	
<b>Conditions of grant:</b> Following are the conditions applying to grants made by The Robert Wood Johnson Foundation. You should read these conditions carefully prior to signing this form. Your signature on this form constitutes your acceptance in full of all conditions contained herein.	
Institutional Approval: Name and title of official authorized to sign for institution:  Larry Meredith, Ph.D. Deputy Director for Operations 101 Grove Street, Room 310 San Francisco, CA 94102 (415) 558-3656	Institutional Approval:   (Signature of authorized official)  Date June 29, 1984  (NOTE: Signature also required on page 4)

\*The project director is the individual directly responsible for developing the proposed activity, its implementation, and day-to-day direct supervision of the project should funds be made available.

RWJF GJ04 (5/83)





## CONDITIONS OF GRANT

To induce the Foundation to make the grant requested hereby, the grantee accepts and agrees to comply with the following conditions in the event that such grant is awarded.

1. **PURPOSE AND ADMINISTRATION.** The grant shall be used exclusively for the purposes specified in the grantee's proposal, dated June 30, 1984, the Request of Project Support Form on page 1 hereof, and related documents, all as approved by the Foundation. In the event that the funds are not used for these purposes within the time specified in the grantee's proposal or within any approved extension of said time period, the funds shall be returned to the Foundation.

The grantee will directly administer the project or program being supported by the grant and agrees that no grant funds shall be disbursed to any organization or entity, whether or not formed by the grantee, other than as specifically set forth in the grant proposal referred to above.

Except as may otherwise be provided in Section 12 hereof, all copyright interests in materials produced as a result of this grant are owned by the grantee. The Foundation, however, retains a royalty-free, nonexclusive and irrevocable license to reproduce, publish, alter, or otherwise use and to authorize others to use any such materials for Foundation purposes.

2. **USE OF GRANT FUNDS.**

- A. No part of the grant shall be used to carry on propaganda or otherwise influence legislation (within the meaning of Section 4945(d)(1) of the Internal Revenue Code).
- B. No part of the grant shall be used to attempt to influence the outcome of any specific public election, or to carry on, directly or indirectly, any voter registration drive (within meaning of Section 4945(d)(2) of the Internal Revenue Code).
- C. The grantee shall not use any part of the grant funds to provide a grant to an individual for travel, study, or similar purpose except under procedures which have been approved in advance by the Secretary of the Treasury or his delegate under Section 4945(g) of the Internal Revenue Code and without prior written approval of The Robert Wood Johnson Foundation. Payments of salaries, other compensation or expense reimbursement to employees of grantee within the scope of their employment do not constitute "grants" for these purposes, and are not subject to these restrictions.
- D. No part of the grant shall be used for a grant to another organization without prior written approval of The Robert Wood Johnson Foundation.
- E. No part of the grant shall be used for other than religious, charitable, scientific, literary, or educational purposes or the prevention of cruelty to children or animals (within meaning of Section 170(c)(2)(B) of the Internal Revenue Code).

3. **BUDGET.** Expenditures of the grant funds must adhere to the specific line items in the grantee's approved grant budget. Transfers among line items (increases and decreases) are restricted to five hundred dollars (\$500) or ten percent (10%) of the approved line item amount, whichever is greater. If a transfer in excess of this restricted level becomes necessary, the grantee shall promptly request authorization therefore from the Treasurer of the Foundation by letter, giving full details. Such transfers may not be made without prior written approval by the Foundation.

4. **ACCOUNTING AND AUDIT.** A systematic record on a fund-accounting basis shall be kept by the grantee of the receipt and disbursement of funds and expenditures incurred under the terms of the grant, and the substantiating documents such as bills, invoices, cancelled checks, receipts, etc., shall be retained in the grantee's files for a period of not less than four (4) years after expiration of the grant period. The grantee agrees to promptly furnish the Foundation with copies of such documents upon the Foundation's request.

The grantee agrees to make its books and records available to the Foundation at reasonable times.

The Foundation, at its expense, may audit or have audited the books and records of the grantee insofar as they relate to the disposition of the funds granted by the Foundation, and the grantee shall provide all necessary assistance in connection therewith.

5. **REPORTS.** Narrative and financial reports shall be furnished by the grantee to the Foundation for each budget period of the grant and upon expiration or termination of the grant. Such reports shall be furnished to the Foundation within a reasonable period of time after the close of the period for which such reports are made. The narrative report shall include a report on the use of the funds in compliance with the terms of the grant, the progress made by the grantee towards achieving the grant purposes, and any problems or obstacles encountered in the effort to achieve the grant purposes.



The financial report should be in the same format as the approved grant budget, and should show the amount budgeted for each line item, the amount expended against each line item as of the date of the report, and the resulting balance remaining in each line. Totals should be shown for each of the three columns. If an encumbrance system is used, encumbrances should be shown in a separate column from cash expenditures.

The Foundation may, at its expense, monitor and conduct an evaluation of operations under the grant, which may include visits by representatives of the Foundation to observe the grantee's program procedures and operations and to discuss the program with the grantee's personnel.

6. **FOUNDATION USE OF DATA AND PUBLIC USE DATA TAPES.** The Foundation shall retain a nonexclusive, irrevocable, royalty-free license to use and to license others to use any and all data collected in connection with the grant in any and all forms in which said data are fixed. If the box below is checked, the grantee shall, at no additional cost to the Foundation, cause public use data tape(s) to be constructed (with appropriate adjustments to assure individual privacy) in accordance with the specifications of the Inter-University Consortium for Political and Social Research, University of Michigan, including the full tape documentation outlined in the Consortium's current data preparation manual. Unless the Foundation shall otherwise specify, such public use data tape(s) shall include all data files used to conduct the analysis under the grant. One computer-readable copy of such public use data tape(s) and the tape documentation shall be transmitted to the Foundation within ninety (90) days after termination of the grant for deposit with the Consortium.

☐ Public use data tape(s) and full documentation required.

7. **PUBLIC REPORTING.** The Foundation will report this grant, if made, in its next Annual Report. The Foundation does not usually issue press releases on individual grants; however, should it elect to do so, it would be discussed with the grantee in advance of dissemination. The grantee may issue its own press announcement, but shall seek approval of the announcement from the Foundation before distribution. In addition, the grantee will be asked to review and approve a Program Summary briefly describing the grantee's activity which will be used by the Foundation to respond to inquiries and for other public information purposes.

The grantee shall send to the Foundation copies of all papers, manuscripts, and other information materials which it produces that are related to the project supported by the Foundation.

In all public statements concerning the Foundation — press releases, annual reports, or other announcements — grantees are specifically requested to refer to the Foundation by its full name: The Robert Wood Johnson Foundation.

8. **GRANTEE TAX STATUS.** The grantee represents that it is a nonprofit, tax-exempt organization as defined in Section 501(c)(3) of the Internal Revenue Code and is not a private foundation as defined in Section 509 (a) of the Internal Revenue Code. The grantee shall immediately give written notice to the Foundation if the grantee ceases to be exempt from Federal income tax under Section 501(c)(3) or its status as not a private foundation under Section 509 (a) is materially changed. The grantee agrees to apply the proceeds of the grant solely to exempt purposes specified in Section 170 (c)(2)(B) of the Internal Revenue Code.

It is expressly agreed that any change in the grantee's tax status or any use by the grantee of the grant proceeds for any purpose other than those specified in Section 170 (c)(2)(B) of the Internal Revenue Code will terminate the obligation of the Foundation to make further payments under the grant.

9. **CERTIFICATION REQUIRED WHEN GRANT MAY BE USED FOR RESEARCH INVOLVING HUMAN SUBJECTS.** If the grant is to be used in whole or in part for research involving human subjects, the grantee hereby certifies that an institutional review board, which applies the ethical standards and the criteria for approval of grants set forth in Department of Health and Human Services policy for the protection of human research subjects (45 CFR part 46, as amended from time to time), has determined that the human subjects involved in this grant will not experience risk over and above that involved in the normal process of care and are likely to benefit from the proposed research program.

10. **GRANT REVERSION AND TERMINATION.** If the grant is intended to support a specific project or to provide support for a specific period of time, any portion of the grant unexpended at the completion of the project or at the end of the time period and any authorized extension thereof shall be returned to the Foundation within fifteen (15) days.

The Foundation, at its sole option, may terminate the grant at any time if (i) the grantee ceases to be exempt from Federal income taxation under Section 501(c)(3) of the Internal Revenue Code; (ii) the grantee's status as not a private foundation under Section 509(a) of the Internal Revenue Code is materially altered; or (iii) in the Foundation's judgment, the grantee becomes unable to carry out the purposes of the grant, ceases to be an appropriate means of accomplishing the purposes of the grant, or fails to comply with any of the conditions hereof.

If the grant is terminated prior to the scheduled completion date, the grantee shall, upon request by the Foundation, provide to the Foundation a full accounting of the receipt and disbursement of funds and



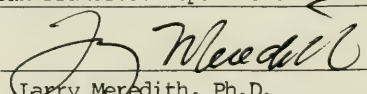
expenditures incurred under the grant as of the effective date of termination. The grantee shall repay within thirty (30) days after written request by the Foundation all grant funds unexpended as of the effective date of termination and all grant funds expended for purposes or items allocable to the period of time subsequent to the effective date of termination.

11. **LIMITATION; CHANGES.** It is expressly understood that the Foundation by making this grant has no obligation to provide other or additional support to the grantee for purposes of this project or any other purposes. Any changes, additions or deletions to the conditions of the grant must be made in writing only and must be jointly approved by the Foundation and the grantee.
12. **SPECIAL CONDITIONS.** The grantee accepts and agrees to comply with the following Special Conditions (if no Special Conditions are imposed, so state):

The foregoing conditions are hereby accepted and agreed to as of the date indicated.

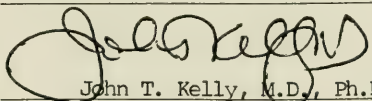
Date: June 29, 1984 Grantee Institution: San Francisco Department of Public Health

By:

  
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Date: June 29, 1984



Appendix 10

P u b l i c a t i o n s





Appendix 10.1

"Toward a Better Service Delivery System for the Homeless Mentally Ill"

By

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"A program which recognizes dependency  
without punishing it or exacting conformity  
to social norms is likely to be unpopular"  
(Rosenblatt, 1974)

If there is a point of absolute consensus in the literature on the homeless mentally ill, it is the fact that they have concerned public authorities for centuries. Given this long period of contact, it is sobering to note the limited repertoire of responses developed by these authorities to deal with them. The most primitive response, dispersion, is also the least ambiguous in its intent. From the launching of the first ship of fools, to the establishment of residency requirements for public assistance, an effective means to dispose of the unwanted has been to move them on. This tradition endures in the passing of clients among catchment areas, and in the belief that good services "attract" undesirables.

A rehabilitative approach to the homeless is more complex, since it attempts to dispose of behaviors, rather than people. The rehabilitation response provides assistance on the condition of personal change, reform, or redemption. (A variant to this can be seen in the charitable reaction, which emphasized redemption of the giver, as well as the recipient of services. However, simple charity has not prevailed as social policy since the State supplanted the Church as dispenser of alms.) Early poorhouses and workhouses exchanged shelter for labor and contrition. The current debate about the function of public shelters and the risk of "promoting dependency" suggests a continuing desire to strike some kind of bargain with the destitute, and to transform indigence into productivity.

The asylum movement reflected this perspective, promising "physical and moral improvement" of the insane (Dix, 1843). Mental hospitals came to serve another function, that of containment or incarceration, at a later point in time. With the accumulation of a population considered "untreatable", they approached the indigent mentally ill in the manner of the prisons from which they drew their initial patients. A different type of bargain was struck: those who could not alter their ways were obliged to cede their autonomy.

Whatever the "swings of the pendulum", from dispersion, to rehabilitation, to containment, we can discern two central strands. The first is a refusal to



support dependence without somehow changing or isolating it. The second involves a failure to differentiate between the varied groups classed under headings such as "wandering madmen", the "indigent insane", or lately, the "homeless mentally ill". These problems may have been inevitable in the distant past, because of limited psychiatric knowledge and absence of community services. Acknowledging the persistent shortcomings of treatment and support services today, we are nevertheless in a position to do better.

We have the advantage of access to a developing body of literature on residential instability and psychiatric disorder which allows us to consider the homeless in a complex fashion, and to formulate some tentative proposals about service requirements. These descriptive reports, most of which were published from the mid-1970's until the present, reflect the concerns and methodological strategies of a number of independent investigators. As such, they provide a glimpse at various aspects of homelessness among the mentally ill, and not a firm data base. However, the combined effects of these separate contributions shed some light on the social and clinical problems found among the homeless, and their relationship to mental health services thus far.

#### The Mentally Ill Among the Homeless:

Other contributors to this volume have discussed the origins of homelessness in some detail, including the economic factors which presently expand the numbers of the urban poor, and the replacing of the stereotyped skid row male with a heterogeneous population. The mentally ill comprise a vulnerable and sizable subgroup of the urban homeless in virtually all areas, and public shelters (Jones, 1983; Ball, 1982; Farr, 1983; Baxter and Hopper, 1981; Segal et. al., 1980; Arce et.al., 1983; Spitzer et. al., 1970; Reich and Siegel, 1978; Haggstrom, 1974). They include a fairly consistent male to female ratio (approximately three quarters male), and a number of younger adults. Where diagnostic information is provided, schizophrenia forms a leading, but hardly an exclusive problem. Alcoholism, once the principle diagnosis on skid row, has become a secondary issue for the majority.

Beyond these broad communities<sup>5</sup>, most samples of homeless cases vary in terms of characteristics such as treatment history, specific type and duration of homelessness, clinical issues and helpseeking behavior. A



considerable amount of effort has thus been devoted to describing subgroups among the undomiciled who appear to present special constellations of these characteristics.

#### The Search for a Clinical Typology:

The distinction between former institutional residents and younger adults amounts to a recurring theme in the literature. Reich and Siegel, for example, find a clear line of demarcation separating the deinstitutionalized paranoid schizophrenic men on New York's bowery from younger, more asocial residents (1978). The former state hospital groups are described as accepting medication but otherwise difficult to reach with conventional services. In view of the "harshness" of their daily lives, their medical problems, and their need for distance, the authors recommend "on site" psychiatric services for this group, treatment which is accessible in shelters and other agencies where the homeless meet their subsistence needs. This point recurs in other discussions of severely disabled and disaffiliated groups (Baxter and Hopper, 1981, 1982).

Younger adults, in contrast, share the experience of mental hospitals via the revolving door. Segal, Baumohl and Johnson consider a group of young male vagrants in a university area (1977). While described by the authors (and by the non-mentally ill on the streets) as severely disturbed, they do not show the degree of physical and functional disability encountered among the ex-hospital group, and are capable of reorganizing rapidly after an acute decompensation. Because their experiences with psychiatric services have been involuntary, and because they cannot locate agencies which meet their first order needs on their own terms, they prefer a "poor" label to a "crazy" one. In addition to their volatility and lack of social resources, migratory behavior acts as an important impediment to their care. Many claim to live in the area where they were surveyed for less than sixteen months.

In fact, this type of mobility has received attention in its own right as a means of identifying subgroups among the undomiciled. Reports of the "Wandering Mentally Ill" (Traveler's Aid Society, 1976,) the "Mobile Mentally Ill" (Traveler's Aid Society, 1978), the "Runaway Americans" (Goldberg, 1972), or "Long Distance Patients (Chmiel et. al., 1979) attempt to describe the movement patterns of transient clients, their





motivations for flight or wandering, and their clinical attributes. The population described by these sources includes the seriously ill, both young and older. Their precipitants to flight appear diverse enough to preclude generalization about them, at least given the restricted amount of data available. The common problem is their lack of personal, social, and economic resources when they arrive at their destination, and the unwelcome burden they impose on local agencies.

Arce and his coworkers offer a typology of the homeless mentally ill which attempts to draw together factors such as old vs. new chronicity, type of residential instability, and service requirements. His classification emerges from data obtained among a Philadelphia shelter sample, 84.4% of whom were considered to be mentally ill (1983). "Street people" (those homeless for more than a month) tend to be older, to have public hospital histories, to require more shelter time and more intensive psychiatric services (including medication), and to be referred to boarding homes (from which many never return). The "episodically homeless" (more than one day but less than one month), tend to be younger, less disturbed than the street people, but more disturbing to others. Many have friends or family to return to, following a shelter episode. A residual group is "situationally" homeless.

At the psychiatric emergency service at San Francisco General Hospital we have also tried to develop some understanding of the undomiciled groups within our client population. Since the late 1970's, a consistent proportion of this clientele, approximately 25 - 30 percent have been unable to provide a local San Francisco address at the time of their PES visit. Initial attempts to compare these cases with residentially stable clients identified few differences. Like the emergency service cases described by Lipton, Sabatini and Katz, (1963) they included many younger adults. So, however, does our overall clientele. The undomiciled were admitted on a voluntary basis at the same rate as other, and showed the same serious diagnoses which predominate in this service.

A 1981 study looked more closely at the residential status of 124 representative cases in the PES, placing them in homeless, transient, or stable groups on the basis of living situation and mobility within the past month (Chafetz and Goldfinger, in press). These groups were then compared in terms of symptoms, using the Patient Evaluation Form (Spitzer and Endicott,



1972). Except for higher ratings of social isolation and impairment of routine and leisure activities (both almost synonymous with homelessness), the residentially unstable resembled their diagnostic counterparts. A possible explanation for this similarity was found in the prior psychiatric records of these cases. Homelessness appeared to figure as an episodic event in so many lives that the homeless, transient, and stable groups of our cross-sectional study might be essentially the same people, observed at a given moment in time.

Data more recently obtained by Surber et. al. (1982) would support this interpretation. In the same setting, he finds that 30% of the PES contacts have no local address at any specific moment in a year. However, of the clients treated 3 or more times in a year 10% have no address at any time, but 70% are undomiciled at at least one such emergency care episode. The meaning of these figures is difficult to determine, since the psychiatric emergency service clientele, and particularly this high service use group may not be reflective of the homeless mentally ill in a general sense. However, the magnitude of the population exposed to residential instability at some point in the year should at the very least alert us to the danger of attributing special characteristics to homeless individuals.

Indeed, while examples of homeless "subtypes" are easy to find among our clientele, running the gamut from persons evicted and in personal crisis, to long term street dwellers, we question whether changing circumstances cannot transform one type of person into another. Segal and his co-workers bring up the same issue, suggesting that many of their young vagrants will eventually settle among the "old guard" of skid rows areas (1980). Arce (1983) allows that the episodically homeless of today may include some of tomorrow's "street people", particularly in view of the debilitating and isolating conditions of living they endure. Kinds of people, or kinds of living situation? This question remains unresolved. In any case, the impression is one of diversity. Whether the old chronic-new chronic distinctions prove valid, whether the mobile client differs materially from the street dweller, whether severe personality disorders become incipient psychoses, it appears clear that <sup>one</sup> no treatment approach will suffice for any subgroup. It may be that none will meet the needs of any individual over time.

Given the current level of concern about the urban homeless, and the



enduring public tendency to disperse, change, or isolate the undomiciled mentally ill, the pressure may be intense to provide a single, "shotgun" service program. As Slater has observed, one facet of American pragmatism is the desire to resolve complex social problems "by gesture" (1971, p. 13). Yet if the past teaches us anything with regard to homeless clients, it is that simplistic and unitary responses tend to fail. Rather than proposing one program to address the needs of these complex individuals, we propose properties of a mental health system which should be present to address the phenomenon of homelessness when it occurs among the mentally ill.

### The Services

Although in the last several years small pilot projects have been designed to serve this population (such as The St. Francis Residence in New York, San Francisco Support Services, the Los Angeles "Skid Row" Project), there has been no consistent nor coherent network of services directed toward meeting their needs. In fact, one of the most significant findings in the Report on Federal Efforts to Respond to the Shelter and Basic Living Needs of Chronically Mentally Ill Individuals (D.H.H.S., D.H.U.D., 1983) was the need for "a continuum of residential options for this population". These patients are frequently extremely difficult to engage in treatment; previous experience within both the shelter system and the mental health system have left them suspicious and distrustful of a service system that has consistently failed to address their problems (Segal and Baumohl, 1980, Baxter and Hopper, 1981, 1982, Larew, 1980). Given their wide range of difficulties in multiple spheres and, therefore, the frequency with which they require services in multiple sites and modalities, they appear particularly vulnerable to issues of lack of coordination, disuniformity of treatment or service philosophy and disparities of objectives and referral protocols. Given the enormous size of the homeless population and the small number of available services, it becomes relatively easy for an individual shelter to ignore the specialized needs of the mentally ill or to justify their exclusion on the grounds of behavioral problems.

Within the community mental health system, also overcrowded and underfunded, the specialized needs of the undomiciled may once again lead to their **exclusion**. Chafetz and Goldfinger (1984) studying the residentially unstable in an urban psychiatric emergency service write:

"An influx of undomiciled and ill-housed clients has placed a strain on staff and this service who cannot always locate residential referrals following short of hospital admission at least on an emergency basis. In the words of one clinician, 'even before you see a client if you know he has a family and a place to live you feel relieved. If you



know he has no where to live, your stomach goes into a knot".

Many traditional mental health interventions are predicated upon the assumption of a stable support network and permanent residence. Asking the patient to "return home, take the medication , rest and come back tomorrow" is a meaningless intervention where home is an alleyway and rest is impossible. Viewed as unmotivated or at least ambivalent towards services, these individuals with multiple problems are frequently excluded in favor of others who, although in genuine need, are also more willing and or able to cooperate and participate in the treatment offered. Few mental health sites have staff with either the time, the skills, or the resources to address residential needs of this subgroup.

In most large urban centers a large plurality of these patients is concentrated in the inner city. The agencies responsible for serving the homeless mentally ill may include the Department of Social Services, Public Health, Community Mental Health, and Housing. These disparate authorities bring to their work divergent philosophies, utilization criteria, standards for clinical accountability and referral procedures. Such overall program planning as does exist is frequently administrative rather than clinical in nature and suffers from the absence of a supervisory structure capable of monitoring programmatic responsiveness to identified needs. Independently functioning services suffer from the lack of a clear mandate to serve this population and do not have the ability to institute interventions other than those for which they were specifically established. Priorities for the population to be served are often non-overlapping and the services without formal interface. Thus, those patients with at best tenuous links to voluntary treatment often find this barrier sufficiently difficult to overcome that they may choose instead withdrawal and its attendant hazards.

At the county or other fiscal planning level this population's needs may be conscientiously excluded from service priorities. Viewed as somehow less fully residents of the community than those who are more residentially stable, their lack of a local address may be viewed as their lack of local residence. Lumped together with migrants, tourists and "others just passing through", their numbers are excluded from service planning and their needs ignored or left unmet (Larew, 1980). Rather, they're left to shuttle between fragmented aspects of multiple service systems faring as best they can with the complex web of requirements for service eligibility.





Although probably not the most common of examples, it is nonetheless possible for a client to be arrested for vagrancy or public inebriation, picked up by the city police and taken to jail. From there they may well be deemed mentally ill rather than criminal and transferred to a psychiatric inpatient unit. Upon discharge they might be placed in a short-term residential intensive treatment alternative. Upon discharge from that unit, although still without a place to live, they may be referred to a day treatment program. In those cities that use case management as an aftercare modality they may well be lucky enough to be accompanied to the local general assistance or welfare office and be provided with a hotel voucher. But rare is the city with coordinated services ~~that~~ such that the hotel will be near the day treatment center. The patient, tired and confused, may end up withdrawing from treatment. With the end of treatment may come the end of medication, decompensation, behavioral problems and eviction. The patient winds his or her way back to a public shelter or, worse, to the streets.

Even with the absolute assumption of our obligation and wish to serve these clients, the path ahead remains unclear. In this post-deinstitutionalization era, recognition of the difficulties inherent in treating individuals with this multiplicity of problems in community settings are just beginning to be addressed. Our work then, must be guided by such hints as are available in the published works of those familiar with these patients and by our own experience with this population over the past several years.

#### Qualities of a Service System for the Homeless Mentally Ill

In addressing the question of services for this population we are immediately confronted with the difficulties in defining who or what constitutes this population. We must acknowledge that at times we will be describing a subgroup of the mentally ill at a particular point in time, since homelessness is frequently episodic or intermittent (Arce et.al., 1983). Similarly, there is among the undomiciled a subset of individuals who although suffering from a chronic mental illness may only intermittently require mental health interventions. Let us then consider both mental illness and homelessness as \_\_\_\_\_ and the population we describe as residing at the intersection of mental illness and homelessness and to require some sort of external psychiatric and social service supports.



Goldfinger et. al. (1984) in a previous publication delineated qualities which may be considered essential in any effective service system for multi-problem patients. We will list these now and then enlarge upon each of them both as concepts and as manifestations of individual program elements of such a system. The essentials of the services for this group are that they be capable, comprehensive, continuous, individual, willing, tolerant, flexible and meaningful\*.

1. Capable. Naturally, in its broadest definition, a service that is capable of dealing with a clientele inherently includes all of the other qualities listed above. In this context, however, by capable we mean an adequacy of physical plant, staff, resource availability and the capacity to provide service recipients with adequate attention to the evaluation and provision of their needs. Large municipal shelters are usually designed to provide housing for a modal client and frequently lack a sufficiently large or well-trained staff to deal with the disruptive and paranoid client or one who, because of psychological issues, is unable or unwilling to behave according to programmatic expectations. Similarly the mental health system has frequently excluded these clients because of their perceived unwillingness to cooperate in treatment or because their psychological problems are not defined as "treatable".

The demise of the state hospital system for the mentally ill was based in part on its reputation of being inhumane and not providing rehabilitative treatment. Yet, the state hospital did provide both shelter and, even, at its worst, certain aspects of treatment for those it served. The state system, however, was an expensive one, yet it may be equally expensive to provide both shelter and treatment for the homeless mentally ill in the community. Many of these clients have been tried in more cost-conscious treatment options. It is because they have failed there or rather because we have failed them that many of them have become dependent high consumers of our most expensive services. Not only will these patients require a large number of staff, but staff more experienced, sensitive and highly trained as well. A funding mechanism which allows for the simultaneous provision of mental health and shelter services with a range of intensity of structure

\*As always, we are deeply indebted to Leona <sup>L</sup><sub>B</sub>. Bachrach for her discussion of the qualities of continuity of care, which have served as a conceptual framework and inspiration for our thinking and planning. (Bachrach, 1981)



length of stay and intensity of intervention must be developed. Currently, for example, municipal shelters may exclude from their clientele those who receive federal disability benefits and yet the clients may be unable to manage their money in a sufficiently organized manner so as to provide a stable roof. To shift the onus of the inadequate system onto an incapable patient may serve fiscal needs but hardly addresses pressing clinical realities.

## 2 Comprehensive

As we have noted, one of the areas that makes it most difficult to adequately serve the homeless mentally ill is the administrative and fiscal splits between social service and mental health agencies. The social service system in most cities is clearly without the capability of providing the range of what is needed by the undomiciled. Ideally one might envision a system with easily accessible "crash dormitories", more organized brief-stay residences, intermediate length housing both in group and with individual room, system of access to vouchered hotel rooms and finally the provision of adequate permanent dwellings. It may be argued that existing community mental health services already provide a comprehensive network of mental health treatment modalities. For many patients with many kinds of problems perhaps they do. But for many of the homeless unwilling to engage in the bureaucratically entangled treatment system, outreach to the places where they do congregate is needed and frequently lacking. The aftercare system frequently relies on scheduled appointments, regular attendance or the following of carefully established and stringently enforced rules of behavior and participation. An appointment at 1 p.m. sharp is difficult to keep if you live on the street and own no watch. Facing an unusually long line at a public soup kitchen and knowing that the wait will preclude an afternoon session may mean the awful choice between cooperation with programmatic rules and going hungry. Halfway houses and other treatment options with brief lengths of stay requiring patients to adjust to continually changing locals and therapeutic staff may on the surface provide both treatment and shelter, but hardly fulfill those qualities of asylum ideally present in such a system (Bachrach, 1984, Minkoff, 1983). In addition to traditional mental health modalities services must be available to provide for social, economic and other supports. Thus even within those rare communities where both the mental



health system and the social service system may each internally provide comprehensive care and the full range of options the systems themselves are rarely integrated. Lacking the necessary interface, they are therefore functionally noncomprehensive.

A system designed to provide shelter for the mentally ill must have access to a full range of outreach, case management, medication and other aftercare treatment modalities. The community mental health system must make available referrals to low cost housing to help provide or augment the possibility of stabilization between acute psychiatric episodes and an access to entitlements which for many of these patients serves as their only tangible evidence of support outside the hospital settings.

Within the services offered an effort must be made to provide more comprehensive care as well. Containment, confinement and medication, like a roof, cannot be all we offer. Life skill, financial management and self-care training, exposure to and discussion of their patterns of social interaction, and personal and interpersonal skills must be accessible to those who want them. Medical care must be made available as this group suffers an extraordinarily high rate of medical and hygienic problems. Substance abuse counseling must be present at every location so as to begin building a recognition in appropriate clients of the interplay between their use of foreign toxic substances and their overall feelings of discomfort and psychic anguish.

### 3. Continuous

Even within a comprehensive range of services discontinuities in the flow of information or in the admission criteria from one level of care to another may show themselves operationally as a lack of available service (Schwartz, et. al., 1983). For example, a stabilized schizophrenic client may be well known to the staff of a shelter that is open evenings only but which he or she has been using for years. During the day, should the patient begin to decompensate and seek services at a psychiatric emergency room, the knowledge of the patient's history and previous functioning might never be made available to the evaluating staff. An admission to an acute inpatient unit using as the core of its data base the emergency room evaluation may result in a total loss of this valuable source of clinical background. Discharge from the hospital with perhaps, referral to a residential treatment facility adds yet another link in the chain of broken communications. When,





after a period of treatment, length of stay criteria force the patient to be discharged from residential treatment, staff at the agency may find themselves in a frenzy over the question of providing ongoing housing for the client. At the shelter, meanwhile, concerned staff may well be desperately attempting to uncover the client's whereabouts yet find themselves left with no centralized source of information despite their concern. The client meanwhile, having told his story to, perhaps, four or five separate sets of intake workers may feel himself misunderstood, overly burdened and ignored evoking a sense of confusion, inconsistency, despair, or disillusionment. Despite the availability of a range of residential and treatment options the very structure of the service system insures discontinuity of care. Although elements of the continuum may be internally of high quality, well designed, and staffed with the best meaning of clinicians, the absence of effective interagency network may render their work ineffective.

The provision of service must be coordinated and monitored from a service perspective that assures delivery of integrated care across modalities and geographic boundaries. It is our feeling that this will only be accomplished by guaranteeing an individual assigned to each client who will serve not only as a nominal but as an actual "case manager" with authority to designate and implement a service plan (Lamb, 1980). Although responsibility for an individual client may be placed in the hands of a single case manager or a team of case managers (The Bridge), it is absolutely essential that case management authority not be vested solely in those at a given site. Rather, an agency with primary responsibility for the client regardless of where they are or how their needs will be met must complement the individualized agency-centered programs. Such case management and coordination cannot exist unless individual programs are uniformly able to be made responsible to (or at least coordinated by) a single identified administrative authority. As long as programs retain the option to refuse to serve specific clients or to establish independent service plans without regard to an overall management policy, continuity of care cannot be achieved.

#### 4. Individualized

Services are easiest to design when intended for large uniform populations. Within the system of services for the homeless the enormity of the problem has made it extremely difficult to focus on the specialized needs of any individual subgroup. Yet the mentally ill homeless are



especially vulnerable and unable to protect themselves or to tolerate the intensity of stimuli at large public shelters. They are at high risk for assault and defeat from both external and internal forces, both physical and psychological. Their behavior, often disruptive, may make them the target of verbal or physical abuse from other sharing their services (Baxter and Hopper, 1983), and the very sensory overload may further their psychological distress. The availability of trained mental health staff at program sites or perhaps more ideally, specific programs with higher staff-client ratios designed to work with this population must be established. Although homeless and in need of shelter, this group is nonetheless psychiatrically disturbed as well and in need of treatment. It is, in many ways, cruel to engage them sufficiently to accept the provision of shelter without acknowledging and addressing their mental health needs. It is precisely because these patients are unable to utilize existing "modal client design" services that they reappear over and over again at inpatient and emergency psychiatric facilities, (regrettably enter our local jails), or leave the shelters provided for them. Yet, the relatively small number of these patients should make it possible to provide within specially designated programs individualized treatment plans targeted to each client's needs.

Similarly, we must recognize that people change over time and our treatment of them must change as they do. Essential to such change must be the recognition of the importance of an ongoing relationship with a single care provider or team. In addition to a role as the treatment coordinator, the case manager designated to work with each of these clients must be able to maintain contact of sufficient frequency and duration to be able to recognize changing patterns of needs and evidence of increased social adaptation or clinical exacerbation. The ability to effectively monitor the current reality of ~~the case~~ <sup>given</sup> ~~and~~ and to help guide the client to the appropriate services necessary at a given time must exist if we are to serve each individual.

##### 5. Willing/tolerant

Sometimes labeled "unwilling" "untreatable" "manipulative", these clients are often met within the mental health system with anger, hostility, and rejection. This attitude is clearly visible to the clients as it is to the referring agencies. We believe that one of the issues is that current services do not fulfill the four qualities listed above. Staff who may be willing to work with these patients under more ideal circumstances recognize the over-



whelming likelihood of failure within the confines and restrictions of current sites. With services specifically designed to meet the needs of this population, it is hoped that the contribution of unrealistic demands on a service and its contribution to an intolerance of these patients will be overcome. Staff are often torn between their loyalty to the clients and their wish to meet the clients needs and loyalty to the institutions in which they work for whom economic reimbursement or length of stay criteria may supercede the focus on any one individual's care.

One of the saddest fates of these clients is the unfortunate tendency to be labeled "manipulative". Frequently their requests of the staff are met with anger and a sense of being "used" by the patient. Perhaps as a function of high case load or rapid turnover throughout the system, staff are unable to become sufficiently acquainted with the internal world of these clients and to recognize both the symbolic nature and relative significance of their requests. One explanation may be that, given a system with such high demand and which is unable to meet the needs of inadequate resources, staff tend to view these clients as "adversaries", thus avoiding the discomforting guilt of recognizing how little they can in fact offer. Perhaps with a system which makes more resources available to staff working specifically with these clients and the freedom and flexibility to establish both short and long term goals, many of these impediments to successful interpersonal interaction and acceptance will be overcome (Goldfinger, 1982).

#### 6. Flexible

Just as within a given modality or site the program must be tailored to meet the individual's needs, the system as a whole must be sufficiently flexible to allow for an optimal utilization of its resources. Thus, the barriers between the mental health's residential treatment system and the social services shelter network, currently essentially impermeable, must be reduced or eliminated. In this way, during times of high inpatient or emergency psychiatric service overload designated shelter residences might be made available for those who could be maintained in less than acute inpatient care and similarly residential treatment facilities might make available group space at night for overflow crowds from the shelter network who would otherwise be denied services. Similarly, medical medication backup must be flexible enough to move throughout the system following the clients where they are rather than tied to specific sites.



Currently many agencies use the guideline length of stay as built into their contracts as absolute and flexible standards against which patients must be moved regardless of clinical need or outside exigencies. In most cases a client who is willing to remain in a service will be kept the maximum number of days tolerated by the system. Discharge and referral plans are tied to this pre-set limit rather than serving as a function of clinical need and appropriateness. Such a model cannot be continued in a new system that hopes to have an impact on these clients. For example, we might envision a joint venture between a large shelter program and the residential treatment alternative. Admission to the residential treatment service would be independent of the requirements for patient-staff contracts currently in vogue, rather, the length of stay at the service might run from 24 or fewer hours to as long as several months. Inability to commit oneself to a long length of stay but rather intermittent short use of the treatment service would not be viewed as a fault of the client or an unwillingness to participate but rather in terms of its individual meaning. For some, it may be another clinical symptom little different from their hallucination or alcohol consumption, or for others, there may be elements of a reasonable and justifiable preference. When the structure or program at a residential treatment service became too intense for the client to tolerate they could instead live at a shelter avoiding the requirements of participation in the more structured treatment program. Perhaps at the multiple shifts between the two services the client would begin to trust the system sufficiently to commit him or herself to a longer treatment course during which more active participation in the program might take place. Such flexibility seems essential if we are ever to be able to make these currently "uncooperative" patients voluntarily willing to accept and participate in our services.

#### 7. Meaningful

When patients come to our services they are rarely requesting treatment. What patients come asking for is help to the extent that the service we offer mismatches the areas for which the patient requests help we can come to understand some of the patient's reluctance to buy a product they never set out to obtain. We may think it important for therapeutic reasons that a client commit himself to regular appointments or a fixed length of stay. Clients, however, have been spared "our" educational and philosophical biases. They frequently see no correlation between what is offered and what they come





for. In order to engage this difficult-to-treat group in our services, we must begin attempting to see what we offer through their eyes. We may view an inpatient admission as a source of diagnostic evaluation, medication titration, and attempts of one-to-one psychotherapy, but for many of these patients it is their only source of hospice without fee and without rules. We may view the long term gains of understanding as a result of regular outpatient psychotherapy as the only intervention which may affect long-term personality change, but to the client who is hungry or without shelter a meal or a roof may be far more important. The therapist who concentrates on taking the history or interpreting relationships, disregarding the client's explicit request for concrete psycical needs has gained little and probably lost the client. Similarly, shelters which require patients to leave during the day may view their motivation as one of increasing the client's sense of responsibility and avoiding institutionalism, but for the clients it is a hostile and rejecting approach when the day may indeed offer no other activities, supports or gratifications. The complexity of intake evaluations, forms and medical or psychiatric assessments may be seen by the shelter worker as helping to provide for a knowledge base on evaluation of the client, but to someone with freezing fingers on an icy night they are just another barrier and example of the system's lack of interest. In order to be meaningful to the clients our services must offer not only what we deem useful but what they deem necessary. For many this will mean positive case management services, targeted to the procurement of entitlements and an arbitration function between the clients and the world around them. The advice and interventions we offer must be relevant to the world they inhabit; it is useless to ask if a person is sleeping well if he is sleeping on the streets or to follow the rules of a shelter program when he or she is responding to internal voices and not ours. Such comments will and probably should be taken by the client as a clear sign that the individual assigned to work for him has little or no comprehension of the realities of their world.

#### 8. Toward a better service system

Designed as a more humanized, respectful and effective method of treating the long-term chronic patient from the state hospitals it replaced, the community mental health system has nonetheless fallen victim to many of the same pitfalls which befell its predecessor. We would like to focus our attention on one specific element of this system's failure. Designed to be accessible to and therapeutic for the large mass of patients, the public



mental health system has great difficulty reacting to the service needs of a patient group requiring specialized or unusual attention. For those patients accepting of and willing to work within its structures, community mental health has provided a positive and useful treatment. But for those patients who by reason of the nature or severity of their internal difficulties or overwhelming social stressors are unable to work within the existing system, it has helped to enforce their over-use of acute services and has resulted in an increase in their sense of alienation, hopelessness and rage.

In many ways, the provision of safe and protective housing for those unable to provide it for themselves has followed a course not dissimilar to that of the mental health system. The recent resurgence of interest in and recognition of the need to provide publicly funded shelter for the homeless population has likewise resulted in a system which, although probably inadequate for the total number of patients does provide a modicum of safety and comfort to those it can serve. Much as the community mental health system, however, it is better able to provide a transition from the streets to shelters for the masses than it is to meet the needs of individually identified subgroups of the clientele it serves. For those willing and able to conform to its policies and protocols a bed and a roof may, in fact, be guaranteed. However, without the ability to address some of the underlying general social causes of homelessness and psychiatric and biomedical roots of the problem, it may provide respite but can accomplish little in terms of long-term impact. Although no longer cold, better rested and better fed, if a shelter system cannot provide access to or direct provision of treatment for the mentally ill among its clientele, it can serve only as temporary respite, but is without ameliorative value.

Bachrach (1983) has focused on the provision of asylum in the care of the chronic psychiatrically disturbed individual. Asylum, as we hope has become clear, is a function falling somehow at the interception of the provision of shelter and of treatment, specifically, a sense of a "safe haven" (p. ). In any evaluation of the service system designed to provide for the needs of the homeless mentally ill we would do well to ask ourselves if we are only providing mental health services and shelter, or are we also offering these clients the asylum they so desperately need.



Rather than offering a description of a model program designed for a given community or a given population, we would like instead to underscore the qualities enumerated above. Within differing geographic areas with diverse political, social and economic concerns and unique client populations and human service problems the specifics of a program to meet the needs of the homeless mentally ill will certainly differ (Turner and Shiferin, 1979; Bachrach, 1983). Although the structure of any service system must, of course, be secondary to these contextual frameworks, we believe that the qualities of the services must embody those factors which we have described.

An element of service planning implicitly but not specifically addressed is that of staff selection and training. We believe that the clinical staff entrusted to work with this group must embody a series of personal and professional characteristics. Some of them certainly must have theoretical sophistication, including the familiarity with the fine points of biopsychosocial diagnosis and an understanding of both psychodynamic and social theories of personalities (Talbot, 1980; Borris, 1978). The staff working with these clients must also be able to call upon a series of pragmatic skills and possess a practical approach to both clinical problem solving and an ability to negotiate a complicated set of social welfare systems. Finally, they must possess what we can only describe as optimistic nihilism. By this we mean that work with this group cannot be effectively managed without a peculiar mix of intense commitment and honest detachment. To work with a group this seriously disturbed, disadvantaged and vulnerable and not to recognize the chronicity of their illness, demanding of them expectations of growth and improvement and significant change may be unrealistic. However, to become overly detached, abandoning these clients as hopeless and untreatable and ignoring the realistic if limited and incremental changes that can be effected is to fall victim to despair. Rather a peculiar mixture of warmth, natural behavior and a ready openness to accept the client as he is must be coupled with the ability to set limits, to refrain from adverse or malicious anti-therapeutic or exclusionary interactions and to maintain a longitudinal relationship despite disruption and frequent rejection. Like the systems in which they work, the staff must be capable, willing, tolerant, flexible and able to find both meaning for themselves and for their clients in their work.



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T R A U M A

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Trauma is one of the leading causes of death and disability among the homeless. Without safe refuge, the homeless are vulnerable to criminal acts such as assault, robbery, and rape. With faculties impaired by alcohol and mental illness, they are particularly susceptible to injuries. Once injured, they may lack access to adequate medical care. Their recovery may be hampered by malnutrition, exposure, or inadequate follow-up care.

Relatively little is known about what kinds of injuries the homeless suffer. A Stockholm study of mortality among 6032 homeless men documented a high incidence of death in the homeless population due to accidents and violence. Of 327 homeless men who died during a three year period, almost 20% died as a result of trauma such as falls, accidents, poisoning, drowning, and murder. The incidence of death in the homeless population due to trauma was twelve times that expected for age-matched controls. (Alstrom, 1975). A study of 227 homeless chronic alcoholics in Toronto revealed a remarkably high incidence of fractures in this population: 30.4% had previous limb fractures, 18.9% had previous rib fractures, and 14.1% had previous skull fractures. (Olin, 1966).

Other indigents, such as single room occupancy (SRO) hotel residents, of whom many are intermittently homeless, are also at great risk for trauma. In a clinic in a large welfare hotel in New York City, trauma was the presenting complaint of almost 20% of the patients. Of the injuries treated, accidents accounted for 52%, assaults accounted for 41%, and burns accounted for the remainder (Brickner, 1972).





Evaluation of the treatment of trauma among the homeless raises a complex array of medical issues. What services are available for treating major and minor trauma and for providing follow-up care? How accessible are these services to the homeless? Are these services able to meet the needs and accommodate the lifestyles of the homeless?

This chapter will describe trauma and trauma care among the homeless by using the experience in San Francisco as a case study. This chapter will describe the types of trauma to which the homeless in San Francisco are subjected, the facilities at which homeless trauma victims receive medical care, and the major problems encountered in providing trauma care to the homeless in San Francisco. Then, using the experience in San Francisco as a foundation, this chapter will discuss general principles and common problems in the care of homeless trauma victims.

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The system for the treatment of homeless trauma victims in San Francisco is largely defined by the institutions, geography, and population of the city. San Francisco, the 14th largest city in the United States, has a population of 705,408 and occupies 46.4 square miles, a relatively small area. There is one regional trauma center, a single publicly operated free-standing emergency center, one facility for treating victims of sexual assault, and a coordinated shelter system for the homeless.



13.7% of the population of San Francisco lives below the poverty line, according to the 1980 United States Census. During 1983, over 96,000 individuals in San Francisco received General Assistance ("Welfare"). More than 10,000 individuals were homeless at some time during 1983. On any given day during 1983, at least 2000 to 2500 people were homeless, based on the number of clients who utilize the City's emergency shelters and estimates of shelterless persons who have opted not to use the shelters.

The homeless who use the emergency shelters in San Francisco constitute a largely male, single, transient population. Surveys are conducted monthly of the entire population in the shelters. 78% are male, 22% are female. Ages range from 18 to 80, with a median age of 31.4. 52% are White, 28% Black, 11% Hispanic, 3% American Indian, and 2% Asian. 33% have been in San Francisco less than 3 months, 11% from 4 to 6 months, 6% from 7 to 11 months, 10% from 12 to 24 months, and 38% more than 2 years. Of those who have lived in San Francisco less than 12 months, 42% were from California, 37% were from Western and Midwestern states, 18% were from Eastern states, and 4% were from Southern states. 69% are single, 18% divorced or separated, 7% married, and 4% widowed. These statistics indicate that the homeless population in San Francisco is similar to the homeless populations that have been described in other cities such as New York, Philadelphia, Washington, and Los Angeles. (Baxter, 1981; Arce, 1983; Ropers, 1984).

The homeless in the emergency shelters in San Francisco have a



high incidence of alcohol and drug abuse, mental illness, and disability. In interviews of 170 of the shelter residents conducted in March, 1984, 57.6% reported a history of alcohol or drug abuse, and 34.7% reported previous psychiatric hospitalization. In self-responded questionnaires completed by over 200 shelter residents in March, 1984, 29% reported that they were disabled, with the majority being permanently disabled. The homeless are extremely heavy users of medical services. 58.2% reported that they had used emergency services during the previous twelve months, and 22.9% reported that had been hospitalized during the previous year.

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In San Francisco, according to City policy, all major trauma victims are treated at San Francisco General Hospital, a 600 bed acute care hospital, which is the regional trauma center. Minor trauma victims who are indigent receive services at San Francisco General Hospital or at Central Emergency, a free-standing emergency facility operated by the Department of Public Health and located in close proximity to the Tenderloin area in which most of the homeless live.

To identify the types of trauma to which the homeless in San Francisco are subjected the medical records were reviewed at San Francisco General Hospital and Central Emergency. Patients whose address was identified as "streets", "transient", or "no local address" were



considered homeless and formed the basis of this study. This method underestimates the actual numbers of homeless because it excludes patients who were homeless but who gave addresses of shelters, former residences, or mailing addresses.

The record of all patients admitted to San Francisco General Hospital from January 1, 1983 to March 31, 1983 were reviewed. 340 (7.7%) of the 4436 patients admitted during this period were identified as homeless. Of the homeless patients, 52 (15.3%) were major trauma victims. 34 other homeless patients (10%) were admitted because of cellulitis. Although the etiology of cellulitis was not known in all of these cases, many were due to trauma. Thus, trauma and trauma-related problems accounted for approximately one quarter of all admissions of homeless patients to San Francisco General Hospital.

One of the alarming statistics regarding trauma among the homeless is the incidence of repeat trauma and repeat hospitalization. Of the homeless admitted to San Francisco General Hospital for major trauma during the three-month period studied, 47% had prior or subsequent hospitalizations at San Francisco General Hospital. Of these patients, over half had been hospitalized for another episode of major trauma. 6% of the homeless major trauma victims admitted to San Francisco General Hospital during the three-month period studied were admitted again for a second episode of trauma during the period studied.

The records of all patients at Central Emergency from January 1,





1983 to June 30, 1983 were reviewed using the same criteria. Of the 524 homeless patients who were treated during this period, 156 (30%) presented because of trauma. Most of these patients were victims of minor trauma.

The homeless major and minor trauma victims included men and women of all ages, but were typically males from 20 to 39 years of age (Tables 1 and 2). They suffered a great variety of severe injuries, including stab wounds, fractures, head trauma, blunt trauma, multisystem trauma, gunshots, suicide attempts, and burns. Injuries included complex facial fractures, hip fractures, pneumothoraces, and lacerations of the neck, chest, liver, large and small bowel, and tendons of the hands. Stab wounds and fractures predominated and accounted for 65% of the major trauma injuries (Table 3).

The homeless also suffered a great variety of less severe injuries, including lacerations, bruises, contusions, bites, minor burns, simple fractures, sprains, and post-traumatic complications such as wound infections. Injuries included lacerations of the scalp, face, lips, arms, wrists, legs, and feet, and fractures of the nose, arms, and legs. Wounds predominated and accounted for 61.6% of the injuries attributable to minor trauma (Table 4).

At Central Emergency, 85% of the homeless patients with lacerations for which the interval from time of injury to time of presentation was documented presented within six hours of injury. As a result, lacera-

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tions could be cleaned and sutured, and the risks of infection could be reduced.

The impact of trauma on the homeless is better illustrated by consideration of specific examples of major and minor trauma. A 46 year old homeless male diabetic who slept in dumpsters suffered multiple rib fractures when he was crushed after a garbage truck emptied the dumpster into its compactor. A 35 year old homeless female alcoholic sustained a skull fracture when she was brutally beaten and raped by four men in a deserted building where she was sleeping.

Many of the homeless major trauma victims had extended hospitalizations and suffered extended disabilities. Often their marginal living conditions were directly responsible for the complications that they suffered. For example, a 33 year old male stabbed in the abdomen had a hospital course complicated by a bowel obstruction that necessitated additional surgery. After his discharge, he returned to the streets and his incision became infected and dehisced. As a result, he required subsequent hospitalization. Another homeless victim, a chronic alcoholic who had a skull fracture, developed chronic cerebrospinal fluid otorrhea and had recurrent bouts of meningitis.

Others developed permanent and severely crippling disabilities. A 33 year old homeless male became paraplegic from a burst fracture of L<sub>1</sub> sustained when a wall fell on him at a construction site where he slept. A 45 year old homeless head trauma victim developed a



permanent hemiparesis.

Many of the homeless minor trauma victims were injured during assaults. A 44 year old male alcoholic sustained multiple deep facial lacerations during an altercation in which he was attacked with a broken bottle. Others were injured as a result of accidents. A 34 year old alcoholic fell down a flight of stairs and lacerated his chin. The most frequent complication of these injuries was infection. Some were injured as a result of self-inflicted injuries. A 33 year old homeless male slashed his wrists during a suicide attempt; several weeks later he lacerated his wrists again in another suicide gesture.

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A special type of trauma to which the homeless are especially vulnerable is sexual assault. To identify the incidence of sexual assault among the homeless, the records of all patients treated at the Sexual Trauma Service (STS) from January 1, 1983 through September 30, 1983 were reviewed. STS, which is operated by the Department of Public Health, is the facility at which all adult victims of sexual assault in San Francisco are treated. STS is located at Central Emergency and is convenient to the area in which the homeless live.

Thirty-four patients, over 9% of the sexual assault victims treated at STS during the nine-month period studied, were homeless. As the homeless comprise less than 0.4% of the population of San Francisco, the incidence of treated sexual assault among the homeless



is more than twenty times as great as that for the rest of the population.

Although women comprise only 22% of the homeless population, they accounted for over 76% of the homeless sexual assault victims. Most of the victims were from twenty to thirty-nine years old (Table 5). They were subjected to a wide range of assaults: 29% were vaginal, 15% were rectal, 3% were oral, and 41% were multiple-orifice. 12% of the assaults were attempts only. Half of the victims had injuries, ranging from minor trauma such as sprains and abrasions to major trauma such as skull fractures. All of the victims experienced some degree of psychological trauma.

At STS 84% of the homeless sexual assault victims for whom the interval between time of assault and time of presentation is known presented within twenty-four hours of the assault. Consequently, injuries could be evaluated promptly, prophylaxis against venereal disease and unwanted pregnancy could be provided, and safe shelter could be arranged.

The incidence of repeat sexual assault among the homeless is also alarming. 12% of the homeless sexual assault victims during the nine-month period studied had been treated previously at STS for one or more prior sexual assaults. One patient was sexually assaulted twice during the period studied.

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The medical system that provides trauma care to the homeless in San Francisco is complex and presents many obstacles for patients. San Francisco General Hospital is located approximately two miles from the downtown area where the food and shelter programs for the homeless operate and where the homeless spend most of their time. Although this geographic separation is of relatively little consequence to the victims of major trauma, because they are usually transported by ambulance, minor trauma victims must walk or have money to pay for bus transportation in order to receive care at San Francisco General Hospital. Whereas major trauma victims are treated immediately at San Francisco General Hospital, minor trauma victims often must wait up to eight hours for treatment in the Emergency Department.

Follow-up care is problematic once patients are discharged from the hospital or the Emergency Department. Clinic appointments at San Francisco General Hospital are severely limited because of space limitations and fiscal constraints. Waits of several weeks or more are common for appointments to surgery and orthopedic clinics. The outpatient clinics are located at the hospital, which is inconvenient for most of the homeless. Transportation to clinic appointments is unavailable. To attend a clinic often causes an impoverished patient to miss eating that day because there are no food programs near the hospital. Patients who present to the Emergency Department for follow-up care often must wait many hours to receive a wound check or have a dressing changed.



Central Emergency is more accessible to patients, because it is located near where they live. Central Emergency is open around-the-clock and treatment is available on a drop-in basis, without appointment. Waiting times are usually less than fifteen minutes. Central Emergency is excellent for wound checks and dressing changes. However, the staff at Central Emergency do not have access to patient records at San Francisco General Hospital, nor is there radiographic or laboratory capability.

Another facility available to the homeless is St. Anthony's Clinic, a free clinic located adjacent to St. Anthony's Dining Room, which feeds two thousand to twenty-five hundred homeless people daily. St. Anthony's Clinic is accessible to the homeless and is available to provide wound checks and dressing changes as well as general medical care. However, the Clinic is only open weekday mornings and, because of staff and space limitations, many patients are turned away daily.

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A complex variety of support programs for the homeless in San Francisco play an important role in the delivery of services to homeless victims. The most important program is the Emergency Shelter System, which was established in 1982. This System, which is supervised cooperatively by the Mayor's Office and the Department of



Social Services, is an elaborate system consisting of approximately 800 beds in residential hotels and approximately 400 cots at the Salvation Army, St. Vincent de Paul Society, Hospitality House, and the Episcopal Sanctuary.

Everyone who requests shelter is provided with shelter through the Emergency Shelter System. The hotel rooms are given preferentially to people with serious medical conditions and to families with children. Recuperating homeless trauma victims, including those discharged from San Francisco General Hospital and those treated as outpatients at San Francisco General Hospital and Central Emergency, are provided with clean and safe quarters. The availability of shower and bathroom facilities are especially helpful for victims with wounds.

The staffs at the shelters play important supporting roles in the delivery of medical services. The staff members, who are generally former homeless persons, have been instructed by representatives of the Department of Public Health how to summon emergency aid and how to care for a patient until an ambulance arrives. The staffs at the shelters have also been taught how to recognize minor trauma as well as other emergencies that may not be life-threatening but which require medical care.

The shelters have medical supplies including basins, wound-cleaning solutions, antibiotic ointments and dressings. With these supplies the shelter staffs administer first aid and assist patients



in providing follow-up wound care.

The shelter staffs are assisted by student nurses who work several nights each week at each of the shelters. The student nurses provide first aid and follow-up wound care, help patients and staff identify what treatment injuries require, and refer patients to appropriate facilities.

This comprehensive and cooperative program of support services for the homeless has heightened understanding of the importance of proper initial and adequate follow-up care of trauma, has improved referral patterns, and facilitates recuperation of the homeless trauma victim.

The shelter program has been cost-effective as well as humanitarian. It costs less to shelter one hundred people nightly in a hotel or shelter than to care for one patient for one day on the trauma service at San Francisco General Hospital. Because of the availability of safe facilities in which patients can recuperate, trauma victims can be discharged earlier from San Francisco General Hospital. Recuperating patients in the shelters develop fewer complications such as wound infections and cellulitis than do patients discharged to the streets. Patients who do develop complications are usually referred for care earlier than those who live on the streets.





The system for the treatment of homeless trauma victims in San Francisco is likely unique. Nevertheless, the problems of homeless trauma victims in San Francisco are the same as those in other cities. Thus, despite whatever peculiarities might exist in the institutions of San Francisco, the general principles that can be identified regarding the treatment of trauma among the homeless in San Francisco are applicable to other locales. The following sections will describe some general principles for providing trauma care to the homeless.

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The management of trauma among the homeless is a complex, multifaceted problem. Prehospital care, emergency services, inpatient care, and outpatient follow-up are each important components of the treatment of trauma.

In all major trauma, successful treatment requires initiation of definitive treatment within minutes. The gravity of the problem must be identified by the victim or those with him. Emergency help must be sought, usually by calling for an ambulance. Ambulance dispatchers must understand the severity of the situation. An ambulance must respond rapidly to the scene. Paramedics must correctly identify the severity of the victim's condition. They must initiate life-saving measures and they must transport the victim in rapid fashion to the appropriate facility.

In dramatic injuries among the homeless, such as stabbings or



shootings, this complex sequence of interventions often occurs successfully. However, the homeless are also victims of less dramatic but nonetheless major injuries, such as closed head trauma. Observers might incorrectly assume that an unconscious transient on a curb or at the bottom of a flight of stairs is intoxicated although he may in fact have sustained major injuries. Even if injuries are recognized, the homeless often lack ready access to telephones to summon help in a timely manner. Ambulance dispatchers, often inundated with calls from "skid row", may fail to dispatch an ambulance promptly. Paramedics at the scene might attribute a homeless victim's condition to alcohol or drugs rather than to injuries. Other homeless trauma victims, such as those who are "loners" or who live in deserted buildings, might not be discovered until long after they have sustained injuries.

When a homeless major trauma victim arrives in the emergency department, the initial treatment should be identical to that for any other patient. The principal features of the treatment of major trauma include evaluation of respiratory and circulatory status, obtaining a relevant history, thorough physical examination including careful evaluation of mental status, and introduction of life-saving measures such as endotracheal intubation and fluid resuscitation.

A fundamental principle that cannot be violated is the importance of fully evaluating patients. Victims must be recognized as homeless. All injuries must be identified. Complicating conditions common among



the homeless, such as hypothermia or metabolic disorders, must be recognized. Of special concern are alterations in states of consciousness, which are exceedingly common among patients who are alcoholics or drug abusers or who are mentally disturbed. Whereas alcohol, drugs, or mental illness may be responsible for alterations in mental status, head injuries may likewise be responsible. Homeless patients, especially those with other injuries, must be carefully evaluated for possible head injuries. Patients who are infested, disorderly, paranoid, or uncooperative must likewise be fully evaluated, even if treating such patients may be difficult or unpleasant.

After initial treatment, all major trauma victims, especially those with severe multisystem injuries, prolonged hypotension, or pre-existing cardiovascular or respiratory disease, remain at considerable risk. Post-operative complications are common, and include hemorrhage, shock, sepsis, respiratory failure, pulmonary embolism, renal failure, myocardial infarction, and death.

While it is appropriate in the early management of major trauma to focus on acute treatable problems, in the recovery phase is essential to consider conditions such as homelessness, alcoholism, drug abuse, and mental illness that might interfere with recovery or necessitate changes in treatment plans. Many complicated management issues must be addressed. Does the patient's homelessness necessitate admission although his injury could be treated as an outpatient? Does the patient



have medical conditions such as cirrhosis or tuberculosis that might complicate treatment or recovery? Does the patient require a longer than usual hospitalization because he is homeless? Does the patient insist on leaving the hospital before appropriate treatment is completed?

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In minor trauma, injuries are usually not life-threatening. Nevertheless, significant suffering and even permanent disability can occur if minor trauma is not treated appropriately. Essential requirements for successful treatment are that a victim recognizes that he is injured, understands that medical care is required, knows where to get treatment, and presents at an appropriate facility.

Homeless persons who are intoxicated or mentally ill might not recognize that they are injured or might not present for care in a timely manner. Transients may not know where to receive medical care. At Central Emergency, 15% of the homeless patients with lacerations for which the interval from time of injury to time of presentation was documented presented more than six hours after the time of injury, and two-thirds of these presented more than twenty-four hours after the time of injury. Most of those who delayed presentation had signs of infection when they presented.

Once victims of minor trauma seek medical care, they must be





willing to wait until they have been evaluated and treated. Minor trauma is often accorded low priority in busy emergency departments. As a result, many of the homeless leave before treatment is provided. Others do not even seek treatment because they are aware of the long waiting times.

The general principles for treating minor trauma are the same as those utilized in treating major trauma: obtaining a relevant history, thorough physical examination, identifying all injuries, and providing appropriate treatment

Wound care is of paramount concern among homeless trauma victims because of the high incidence of stab wounds, lacerations, bites, and burns. General principles of initial wound care include removal of dirty clothing; thorough assessment of type of injury, extent of tissue damage, and presence of foreign bodies or other contamination; careful preparation of the wound, including mechanical cleansing and debridement of contaminated or devitalized tissue; proper closure of the wound; protection of the wound with sterile dressings and splints; and instruction to the patient of the rules of wound care and the signs of infection. (Committee on Trauma, 1982) The general condition of the patient is likewise important to assess, because of its impact on healing.

The issue of prophylactic antibiotic therapy as an adjunct to



wound care merits special consideration. Prophylaxis is clearly indicated when treatment has been delayed and in wounds that are highly susceptible to infection, such as bites. Antibiotics are also indicated in patients with debilitating conditions such as diabetes. Patients who are alcoholic or severely malnourished may also benefit from prophylactic antibiotics. Homeless patients often fail to fill prescriptions, frequently lose their medications, and regularly neglect to take antibiotics. It is preferable to provide medications directly to patients rather than to expect patients to have prescriptions filled. Many patients lack resources to purchase even inexpensive medications. It is essential to inform patients of the value of prophylactic antibiotics and the potential risks if they fail to take such medication. It may be valuable to have patients return daily to monitor antibiotic use as well as to check wounds and change dressings.

Tetanus prophylaxis is an important aspect of wound care. The principles of tetanus prophylaxis and the indications for tetanus toxoid and human tetanus immune globulin are well established. Among homeless trauma victims, immunization records are generally unavailable and histories of immunization status are often unreliable. Careful consideration should be given to the use of tetanus toxoid. In patients with tetanus prone wounds such as contaminated lacerations special consideration should be given to the use of human tetanus immune globulin.

The management of homeless sexual assault victims is a complex process that involves evaluation and treatment of physical injuries,



assessment of risk of venereal disease and pregnancy, evaluation of psychological response, and collection of legal evidence. It is preferable to provide prophylaxis against venereal disease and unwanted pregnancy on the initial visit rather than to wait for the return of test results, as it may be impossible to contact victims who are homeless and homeless sexual assault victims rarely return for follow-up. Despite diligent efforts by the social workers at STS, who were able to contact over half of the homeless sexual assault victims, less than 9% returned to STS for follow-up. It is essential that a victim's homelessness is identified and safe shelter arranged so that the victim does not return to the environment in which the assault occurred.

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After initial care has been provided, follow-up care for homeless trauma victims is especially important because their living circumstances place them at great risk for complications such as wound infections and delayed healing. Patients who sleep outdoors and lack shower facilities and changes of clothing are rarely able to keep their wounds and dressings clean and their casts intact. Standard practices, such as weekly wound checks or biweekly cast checks, must be altered for the homeless. Wounds should be checked and dressings changed daily or every other day. Casts should be evaluated frequently.

The homeless generally present infrequently if at all for follow-up care. Hospital clinics, with limited hours and tightly scheduled



appointments that are often overbooked, are often not well suited to accommodate the lifestyles of the homeless. Emergency departments generally give low priority to follow-up care and often require non-acute patients to wait hours before receiving care.

At Central Emergency, only 21.4% of the homeless patients with lacerations that were not infected at the time of initial presentation returned for follow-up wound care. Of the patients with infected lacerations, only 28.6% returned for follow-up. With such poor follow-up, wound infections, prolonged disabilities, and other complications, which often necessitate lengthy hospitalizations, are commonplace.

In planning follow-up care for the homeless, perhaps the single most important need is to identify that patients are homeless, for without such identification appropriate plans might not be made. Physicians, nurses, social workers, and clerks are all important in identifying which patients are homeless. Once it is determined that a patient is homeless, every one involved in his or her care should be informed of the patient's living situation. This fundamental principle is often overlooked. At San Francisco General Hospital, less than half of the homeless major trauma victims admitted during the three month period studied were evaluated by a social worker prior to discharge.

When appropriate, homeless patients should be placed in shelters. Other arrangements that might facilitate care include: thorough ins-





tructions by sympathetic staff of the importance of follow-up care; instruction sheets that detail the plans for medical care; copies of emergency department records or discharge plans (especially valuable for patients likely to receive follow-up care elsewhere); packets of dressings and medications for wound care; daily or twice daily dressing changes; regular visits to shelters by visiting nurses; referrals of patients to facilities with drop-in capability, extended hours, and locations near where patients live. Clinics located in the shelters or in the meal programs for the homeless are often well adapted for providing care. Other valuable resources are the employees of shelters, food programs, detoxification centers, social service agencies, and other programs for the homeless. If the managers and staff of these programs are instructed about the availability of medical services for the homeless, the signs and symptoms of post-traumatic complications, and the indications for referral, they can refer patients who might otherwise not obtain treatment.

Another important factor in providing proper trauma care to the homeless are the attitudes of the staff. This is especially important for follow-up treatment, because so many homeless fail to obtain follow-up care. Staff sympathetic to the problems of the homeless, tolerant of their alcohol abuse and mental illness, willing to treat patients who are dirty or infested, and tolerant of their failure to keep appointments, are more likely to be influential in encouraging patients to return for medical care. Staff willing to tailor treatment to the



needs of the patient are also likely to succeed in encouraging patients to return for follow-up care. If a patient with an infected wound or cellulitis refuses to be hospitalized, it is preferable to treat him as an outpatient rather than to deny treatment altogether.

Many homeless do not seek medical care until they have been injured. However, others obtain treatment for a wide range of problems unrelated to trauma, such as infestations and upper respiratory infections. Often the patient's homelessness is not identified. More often, no effort is made to address the patient's homelessness as a problem. Physicians, nurses and support personnel aware of the risks inherent in being homeless should initiate appropriate referrals to help patient's obtain shelter and thereby reduce their risk of the wide variety of medical problems associated with being homeless, including the risk of trauma. Thus, health workers should play a role in the prevention as well as the treatment of trauma among the homeless.

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Many other issues regarding trauma among the homeless remain to be addressed. Can the incidence of trauma among the homeless be reduced? Can the frequency of complications of trauma among the homeless be reduced? Can the incidence of temporary or permanent disability among the homeless due to trauma be lessened? What are the personal, social, and economic costs of trauma among the homeless? How can trauma care for the homeless be improved?



The homeless are multiply disadvantaged. They lack shelter, food, clothing, and social supports, and they are at great risk for trauma. Once injured, they face enormous obstacles to recovery. Unless medical care is available at facilities accessible to the homeless, with drop-in capabilities and sympathetic staff, homeless trauma victims may not receive essential treatment, may develop preventable complications, and their condition may further deteriorate.



SAN FRANCISCO GENERAL HOSPITAL

Homeless Patients Admitted for Major Trauma (1/1/83-3/31/83)

<u>Age</u>	<u>Male (N=42)</u>		<u>Female (N=7)</u>	
20-29	11	26.2%	1	14.3%
30-39	18	42.9%	4	57.1%
40-49	7	16.7%	0	
50-59	3	7.1%	1	14.3%
60-	3	7.1%	1	14.3%

Table 1





CENTRAL EMERGENCY

Homeless Trauma Victims (1/1/83-6/30/83)

<u>Age</u>	<u>Male (N=138)</u>		<u>Female (N=18)</u>	
<20	2	1.5%	0	
20-29	37	26.8%	6	33.3%
30-39	64	46.4%	5	27.8%
40-49	17	12.3%	0	
50-59	14	10.1%	3	16.7%
60-	4	2.9%	2	11.1%
Unknown			2	11.1%

Table 2



SAN FRANCISCO GENERAL HOSPITAL

Homesless Patients Admitted for Major Trauma (1/1/83-3/31/83)

<u>Primary Reason for Admission</u>	(N=52)	
Stab wound	19	36.5%
Fracture/dislocation	15	28.8%
Blunt trauma	6	11.5%
Head trauma	5	9.6%
Multisystem trauma	2	3.8%
Gunshot	1	1.9%
Suicide attempt	1	1.9%
Burn	1	1.9%
Bite	1	1.9%
Cellulitis	1	1.9%

Table 3



CENTRAL EMERGENCY

Homeless Trauma Victims (1/1/83-6/30/83)

<u>Reasons for Initial Presentation</u>	(N=172)	
Laceration	70	40.7%
Bruise/contusion	29	16.9%
Post-traumatic cellulitis	19	11.1%
Abrasion	10	5.8%
Bite	8	4.7%
Wound follow-up	7	4.1%
Burn	6	3.5%
Fracture	5	2.9%
Sprain	5	2.9%
Puncture wound	3	1.7%
Suture removal	2	1.2%
Ingestion	2	1.2%
Concussion	2	1.2%
Eye injury	2	1.2%
Arthritis/bursitis	2	1.2%

Table 4



SEXUAL TRAUMA SERVICE

Homeless Sexual Assault Victims (1/1/83-9/30/83)

<u>Age</u>	<u>Female (N=26)</u>		<u>Male (N=8)</u>	
< 20	4	15.4%	2	25.0%
20-29	12	46.2%	5	62.5%
30-39	9	34.6%	1	12.5%
40-	1	3.8%	0	

Table 5





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# DESCRIPTION OF HOMELESS VETERANS IN SAN FRANCISCO - OCTOBER, 1985

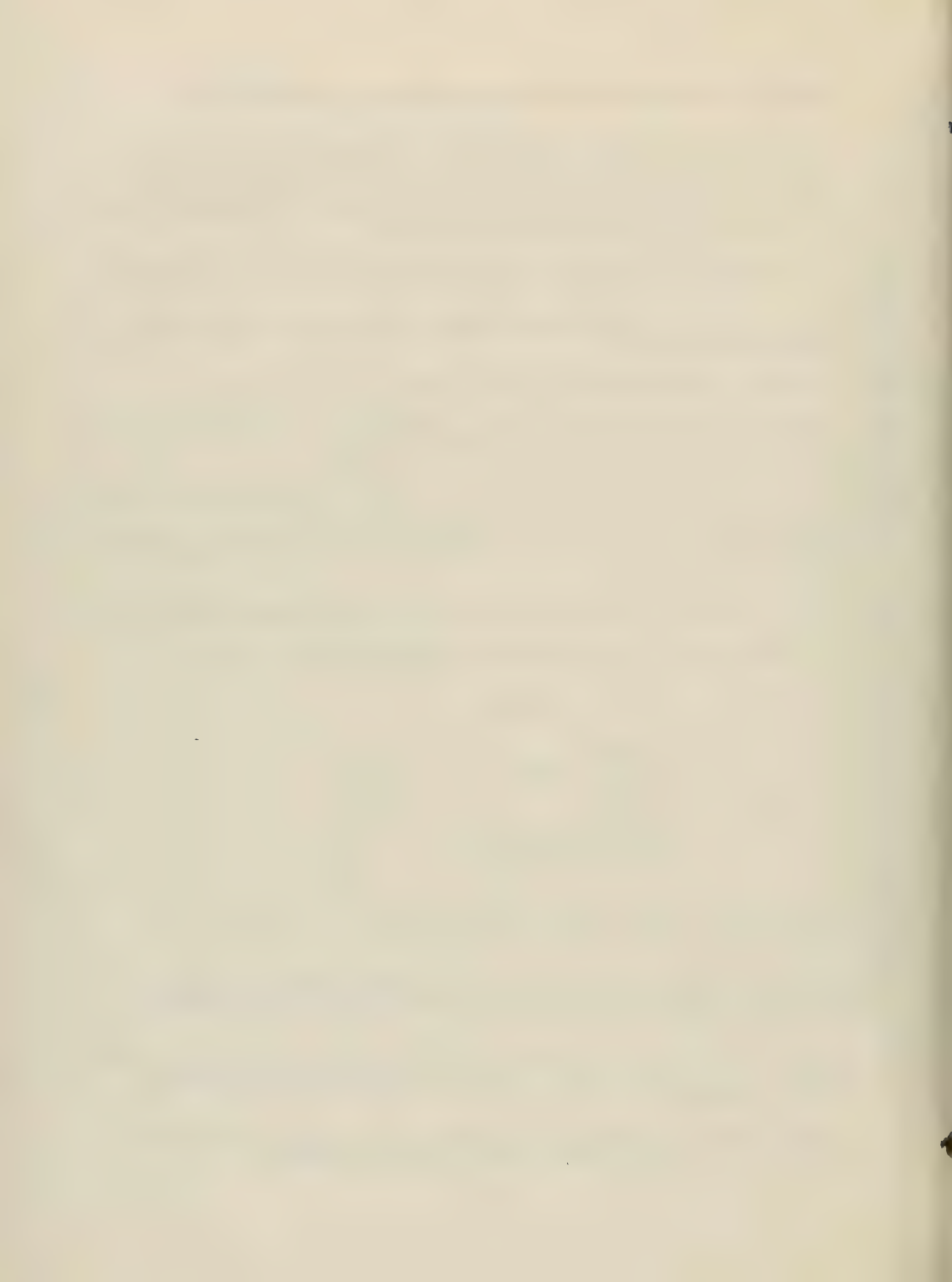
1. In two recent self-administered surveys of homeless persons in the San Francisco shelters, veterans comprised 29.7 percent of persons sheltered in April, 1985 and 31.3 percent in October, 1985. A survey of "street persons" conducted at five locations on September 24, 1985 revealed that 36.4 percent of the respondents were veterans.
2. Shelter surveys reveal that more than 86 percent of the veterans had held jobs for more than one year.
3. Nearly 31 percent of the homeless veterans reported they had permanent physical disabilities.
4. Twenty-five percent admitted to having a mental health problem.
5. Slightly more than 45 percent admitted they had some level of alcohol abuse with 19 percent reporting "severe" alcohol problems.
6. Problems of drug abuse were reported by 24 percent of the homeless veterans.
7. Seventy-eight percent of the homeless veterans claimed to have a "marketable skill," but yet only slightly more than six percent reported some level of income from employment.
8. More than 16 percent reported employment as a need to stabilize their lives.

The following needs were listed by the homeless veterans:

(N = 152)

Housing	21.4%
Job/Job Training	18.1%
Clothing	10.4%
Food	10.4%
Alcohol/Drug Services	9.9%
Medical Services	7.4%
Veterans Assistance	7.4%

9. The average age of the homeless veterans was 41.8 years and the median length of San Francisco residence was 3.0 years.
10. Nearly 79 percent of the homeless veterans reported they had received an Honorable Discharge yet less than five percent were receiving Veterans Administration financial assistance.
11. Of the 152 veterans in the October, 1985 survey, 44 percent (60 vets) were veterans of the Vietnam Era and 74 percent of the Vietnam Era veterans served in Vietnam.
12. Homeless veterans responding to the October, 1985 surveys had spent an average of 107.0 days in San Francisco's homeless shelters.





ANALYSIS OF STREET  
INTERVIEW OF SEPTEMBER 24, 1985  
(N=179)

Number Interviewed:	124	69.3%
Number Refused:	55	30.7%

Sex:

Male	86%
Female	14%

Veteran Status

Yes	36.4%
No	63.6%

Vietnam Era?

Yes	50%
No	50%

- 73 percent said "benefits" didn't last the whole month
- 32 percent reported they had been hospitalized for mental health reasons
- 42 percent reported they had alcohol problems
- 42 percent reported they had had a drink in the past 24 hours
- 21 percent reported they had a drug problem
- 22 percent reported they had been hospitalized in the last 3 months
- 35 percent reported they had sought some form of counseling assistance
- 35 percent reported having been picked up by the police in the recent past - mostly for drinking in public, begging and blocking a sidewalk
- 78 percent reported they ate at congregate feeding sites with 78 percent of them reporting they ate at St. Anthony's
- 45 percent were under the influence of either drugs or alcohol at the time of interview (32.8% alcohol, 11.8% drugs).



### Length of Stay in San Francisco - All Sites

Median: 5.5 years  
Range: 1 day - 67 years

UN Plaza:	Median: 7 months Range: 1 day - 54 years
Powell-Market:	Median: 9 years Range: 3 months - 21 years
Civic Center Plaza:	Median: 6 years Range: 5 months - 37 years
Hallidie Plaza:	Median: 6 years Range: 2 days - 38 years
16th/Mission	Median: 21.5 years Range: 1 day - 67 years

### Length of Time in San Francisco (N=122)

<u>Length</u>	<u>Number</u>	<u>Percent</u>
0-3 mos.	28	23.0%
4-6 mos.	11	9.0%
7-12 mos.	10	8.2%
13-23 mos.	3	2.5%
2-5 yrs.	11	9.0%
6-10 yrs.	15	12.3%
11-20 yrs.	19	15.6%
21 yrs.	25	20.5%
Unknown	(2)	

### o Age - All Sites

Mean: 36.9  
Median: 34.0  
Range: 17-84

U.N. Plaza:	Mean: 32.0 Median: 28.0 Range: 18-73
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Powell-Market:	Mean: 35.3 Median: 33.0 Range: 23-45
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Civic Center Plaza:	Mean: 41.9 Median: 35.0 Range: 31-84
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Hallidie Plaza:                      Mean:    36.  
    Median: 32.0  
    Range: 17-67

16th - Mission:                      Mean:    44.1  
    Median: 41.0  
    Range: 23-75

1. Where Slept on September 23, 1985? (N=122)

	<u>N</u>	<u>Percent</u>
Shelter	20	16.4%
Hotel	27	22.1%
Doorway	40	32.8%
Apartment	3	2.5%
House	10	8.2%
Friends	13	10.7%
Other	9	7.4%
Unknown	(2)	

2. Regularly Stay there? (N=119)

	<u>N</u>	<u>Percent</u>
Yes	95	79.8%
No	24	20.2%
Unknown	(5)	

3. What Do You Do During The Day? (N=119)

	<u>N</u>	<u>Percent</u>
Work	10	8.4%
Library	1	.8%
Streets	48	40.3%
Public Transportation	2	1.7%
Park	38	31.9%
Spare Change	2	1.7%
Look for Work	11	9.2%
Other	7	5.9%
Unknown	(5)	

(Streets + Parks + Spare Change + Library + Public Trans = 91 or 76.5%)











